02 Dovetail
supporting the youth alcohol and drug sector in Queensland

legal and ethical dimensions of practice

youth alcohol and drug good practice guide

Dovetail provides free professional support to any worker or service in Queensland who engages with young people affected by alcohol and drug use. Funded by Queensland Health and delivered by a Consortium of 14 government and non-government agencies, Dovetail seeks to identify a youth alcohol and drug sector, connect its services and workers together, and equip them with evidence-informed knowledge, skills and resources to enhance their practice.

This booklet is one of six Dovetail Good Practice Guides developed in partnership with the School of Public Health and Social Work at the Queensland University of Technology. Through a participatory methodology, frontline workers and managers from across Queensland nominated, explored and shared insights about their direct knowledge, tools, resources and practice wisdoms to inform the pages of these Guides. With additional help and contribution from our friends at the Youth Advocacy Centre and Caxton Legal Centre, this collective wisdom - grounded in the reality of direct practice with young people - comprises a new evidence-base for the sector. Aimed at practitioners across clinical and community-based contexts, we trust these Guides will further contribute to the growing knowledge and skill-base on how to most effectively work with young people experiencing problematic alcohol and other drug use.

legal and ethical dimensions of practice

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Published by
Dovetail
GPO Box 8161
Brisbane, Queensland, 4001.
www.dovetail.org.au

April 2012
ISSN: 0813-4332
ISBN: 978-0-9873015-1-2

Suggested citation

Crane, P. 2012. Youth alcohol and drug practice guide 2: Legal and ethical dimensions of practice. Brisbane: Dovetail.

Acknowledgements

This Guide on 'legal and ethical dimensions of youth AOD practice' has many contributors. The development of specific material was iterative and developed over time through a range of processes and conversations. Thanks especially to:

- the services, practitioners and managers involved in the Dovetail network who contributed their examples, experiences and feedback;
- the Dovetail team of Jeff Buckley, Cameron Francis, Leigh Beresford and Benjamin Dougherty for their extensive feedback on draft material, input and support;
- the Youth Advocacy Centre and Caxton Legal Centre for their feedback on draft material and permission to reproduce sections from their publications;
- the Queensland Health staff from Hot House (Youth Community Team), the Statewide School based Youth Health Nurse Program and Minding Young Minds Program, Child and Youth Mental Health Service in the Children's Health Services, for their expert feedback and input on draft material;
- Linda Shallcross (Ph.D) for her assistance in supporting the involvement and input from services;
- and participants from the '10 Services Group': Adolescent Drug and Alcohol Withdrawal Service (ADAWS); Alcohol, Tobacco and Other Drugs Service (ATODS) - Townsville; Alcohol and Drug Foundation Queensland (ADFQ) - Kingaroy; Boystown - Logan / Ipswich / Redlands; Brisbane Youth Service (BYS); FOCUS - Sunshine Coast Division of General Practice (SCDGP); Gold Coast Drug Council (GCDC); Hothouse (Youth Community Team); Indigenous Wellbeing Centre (IWC) - Bundaberg; and Youth Empowered Towards Independence (YETI) for their feedback and input.

Queensland University of Technology

This initiative is funded by the Queensland Government.

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Material in this Guide should never be taken as providing you or any other person with legal advice. Legal advice regarding the application of the law to a particular circumstance or situation can only come from a legal practitioner. A range of sources for legal advice can be found in the Guide.

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Introduction

This Guide is designed to assist Queensland-based youth AOD workers to better understand and negotiate the complex interplay of ethical, legal and organisational considerations in their practice. Legal, ethical and organisational dimensions of practice heavily condition youth AOD education and training, policy, research, administration, law enforcement, health promotion, prevention, primary care and so on. Given the criminal law and legal status of alcohol and drug possession and consumption in Australia and the age of the client group, these considerations take on particular significance.

As with all the guides in this series, the goal is to provide frontline workers and managers with questions and principles which promote good youth AOD practice. Each of the topics canvassed in this Guide is substantial in its own right. The implication is that this Guide should be used as a prompt for asking questions and seeking further advice and support when a way forward is not clear, or where the consequences of particular courses of action need to be considered more fully. As indicated elsewhere in this series, youth AOD work is heavily contextualised and this will influence how particular aspects of practice are undertaken.

It is understandable for workers and agencies to seek clarity about what they should do in tricky or complex practice situations. This Guide will disappoint in that respect. It is not possible to provide such clarity given the limited amount of case law around practice, the moral basis of ethics, and the spread of responsibility across frontline workers, organisations and governments, and the infinite variety in practice situations. There are no easy answers to the 'tricky stuff', but there is a foundation of information to be aware of and good questions we can ask.

Focus and contents

The target audience for this Guide is direct service practitioners in Queensland, particularly those new to the youth AOD sector. Managers and supervisors may also find it useful as a point of reference, as will workers from outside Queensland, although some content may not be relevant or apply to their particular state or territory.

Please note that for additional information on youth work and the law, refer to Youth Advocacy Centre's handbook "Laying Down the Criminal Law" – www.yac.org.au, and for further information on the law in Queensland refer to "The Queensland Law Handbook" published by Caxton Legal Centre – www.caxton.org.au

Section 1

Dealing with complexity - the 'tricky stuff'

The theme of complexity is threaded through these guides. In any given practice situation the practitioner needs to be aware not only of the context of the young person (or young people) they are working with, but of their own context - most importantly the role they are undertaking at the time, the policies that condition service delivery, various types of laws, and ways of understanding practice that create expectations of what is reasonable and ethical for them to do in a particular situation.

Youth AOD practitioners are almost always working for an organisation, whether as a paid employee, a contractor or a volunteer. Organisations have policies and procedures designed to inform and manage the service delivery process. Whilst important, even these do not fully inform many practice situations. Frontline workers in AOD related practice with young people often say that this lack of direction and certainty can be quite 'scary'.

The reality, as depicted in Figure 1 below, is that practitioners have to deal with and make lots of decisions in the 'grey zone', often in short timeframes. Being able to do this is the 'craft' of the frontline.

Figure 1: Intersecting considerations for practice

If you read no further, take these questions with you as critical to making decisions in frontline practice.

A broad decision making checklist

- What aspects of this situation should I be concerned about?

  In respect of each of these aspects (or together if relevant) answer the questions below:

- What is my role and mandate?
- What does the law say?
- What does my organisation (policies and procedures) say?
- What does my professional framework say? What is good practice in this situation? (practice standards, accepted good practice characteristics and strategies, core values, code of ethics, ethical decision making processes)
- What does my personal framework say?
- What impact/s will/might my decision/approach have on my client? On others?
- What other processes should I use to inform what I do? (e. g., seek advice / information that is necessary and relevant, assess alternative options, apply a particular practice model etc.)
- What else should I consider here?
- On what grounds can I justify what I do?

Source: Adapted from Wight and Hoyer, 2009. 8. Youth Advocacy Centre. [www.yac.net.au]

1.1 What is 'tricky' in youth AOD practice?

There are many tensions and dilemmas that workers undertaking youth AOD practice might experience. Most tensions can be adequately responded to by a worker reflecting on the situation and taking into account various considerations for what constitutes 'good practice' in that specific situation.

Dilemmas are more difficult as these involve needing to make a choice between two or more important principles for good practice. In other words, two or more legitimate principles for practice cannot both be achieved.

What are these tensions? The tensions cited below come from the consultations undertaken in producing this Guide and the Therapeutic Practice Frameworks in Youth Alcohol and Other Drug Services (Bruun and Mitchell 2012).

- The level of autonomy and self determination to afford a young person.
- The nature of the worker - young person relationship, including boundaries.
- The worker's role and compliance with organisational policies.
- The need to consider the role, expectations / requirements of, and duties to, third parties:
  - who are part of a young person's natural network of supports and connection (parents, friends, significant others).
  - who have a mandated role which affect practice (e. g., the courts, youth justice or adult corrections system).
  - who are other service users or parties affected by what happens in practice.
- Limitations arising from the way service delivery is conceptualised, undertaken and/ or resourced within the organisation, or by other parts of the service system. The funding context, the organisational context, the particular model of service, and the service system can be experienced by workers as being in tension with the achievement of good practice outcomes.

The following quotes from frontline workers and managers across Queensland express these tensions in their own words.

Accept the young person's assessment and goals..... Inject realism

We are supporting a young single mum at home with her baby. She wants to be a lawyer. The AOD worker is trying to respect her goals and engage her in a pathway for this through Distance Education! How about we start with finishing year 10?

Let young people do it their way..... Subtly guide and manage them

One of the girls we work with was put on adult probation. She found out she might be being breached, and was worried she might be arrested at the probation office where she needed to go for an interview. We worked really hard to get her to go down to the probation office, but when we walked in the girl turns around and tells her AOD worker to shut up. The probation officer challenges her and it all starts to go downhill. We know that she is emotionally damaged and that she lashes out before she conforms - but other agencies and workers just see her behaviour and try to sanction it or contain it. It's hard. We often have to step in and manage the young person and the situation in a way that reduces tension but is still in their best interests. It's about getting young people to take baby steps - about empowering them to make progress and not blow it all up.

Be supportive..... or openly challenge them

In this work you sometimes have to challenge what a young person is doing or saying they are going to do. It is difficult to do that effectively without having built up a relationship. Our relationship is like having "money in the bank" to withdraw when they are challenged. I call it 'Dancing at the ATM'. At the beginning I have to build up a relationship. When I have a lot of money in the bank through building the relationship I can make a 'withdrawal'. It is possible to try things to see how much I can withdraw - it's about how much you can challenge them at particular times. You can build your money back quite quickly - but often I see workers 'withdrawing' before they have enough 'money in the bank'.

Clear limits, rules and sanctions..... Promoting good longer term outcomes

There is a 20 year old girl who is a regular paint sniffer who we have had to ban. We virtually never ban so this is big - but her emotional regulation stuff is so variable and she becomes so disruptive that we have to do something. We have a great relationship with another service and she goes there when she is banned here. We make sure she is not banned from both services at the same time and up support to the other service in creative ways to help them maintain her with that service. We will also fund her to return to distant but supportive family where there are other supports when everyone is getting burnt out.

Working flexibly and relationally..... Maintaining appropriate boundaries

Boundary issues crop up all the time in this type of work. You know, driving them to appointments, helping them move house, assisting them to pick up their belongings etc. What happens when this begins to feel less like intentional casework and more like a personal assistant? On one or two occasions I've felt like I've inadvertently helped a young person score or deal drugs when in my head I was building a relationship by "helping" them sort out stuff they need to do. It gets really tricky when you're sitting by yourself in a work car outside a house that your client has just entered to pick up their bag or collect some belongings and you begin to suspect that they're actually scoring or using drugs. And then they come back looking a bit affected and you're feeling pissed off because you think you're being used and when you challenge them they get their back up and deny it, and then you're left with a trust issue hanging between you. It's really challenging stuff.

Self determination by young person.....
Over-riding self determination because of risk of harm to others or self

Sometimes it can be difficult when you work in informal or semi-structured environments, such as public-space or 'street-based' outreach. It can be heaps easier to build rapport and trusting relationships when they feel safe and have a greater sense of control, but what do you do when those young people begin drinking, smoking pot or talking about their drug deals in front of you. And what do you do when a young person asks you for one of your cigarettes? Might be good for building a relationship, but is it condoning or tacitly supporting unhealthy behaviour?

Always being too busy..... Taking time to orient, reflect, understand and let young people get comfortable with you

At the drop in centre new workers need to move slowly at the start. You can't push the relationship. You can try to build rapport as quickly as possible but you can't do it quicker than they are ready for. That applies to the skills of the new workers as well as the young people.

Wishes / expectations of a young person.....
Wishes / expectations of parents / guardians

I'm working with a 15 year old young woman who was referred to me by her parents for using illegal drugs. Her parents want her to attend AOD counselling and abstain from drug use or they will report her to the police. She doesn't want to stop using drugs and begs me not to tell her parents. I consider her usage to be risky and that she would benefit from some harm minimisation information, but her parents won't support this. How should i proceed? and what should i tell her parents next time they ask me how she is doing?

Individual focus.....Relational focus

Sometimes a simultaneous focus is best. We work with a sister who has taken on the care of her two brothers. She is the key client. But it is easier and more productive to work with all three rather than just one. So we work with all of the siblings and try to fit that into the program and funding criteria.

Comply..... Not comply?

The organisation has a 'two worker' policy in terms of home visits. But sometimes we just don't have the resources to do this and as a key worker I have to decide if I am going to keep faith with the young person and the family. It may have taken ages to set up a meeting with the father and then something happens and the other worker or Coordinator isn't available. Sometimes in practice timing is everything.

When should I reassess risk and not comply with the organisational policy if it is prudent?

Amount and focus of organisational policies.....
Good judgement and skills

We have so many policies and procedures it is impossible for a new worker to be across them all. And some of the time our policies don't quite match up with policies of other agencies we are working closely with. At the end of the day we need workers who have a good sound way of working, can problem solve, work well with young people, and who can deal with complex demands.

Providing information to authorities that may help a client..... Gaining prior informed consent

Often my role involves being at the Special Circumstances Court and I'll be called in front of the Magistrate. It's very informal and they ask you questions on the spot. When you know the detail of that young person's story … you know they have a child at home, or an abusive partner, or they have a parent to look after, … yet they need to go to detox … it's very, very complex. And we are trying to advocate for them in a way that has the best outcome for them and maintain a relationship with them at the same time in a way that we don't blow the trust.

Helpful case notes..... Anticipating forced disclosure

One of the tensions for me is when we write case notes, which we do straight onto a database to record information that's helpful. They tell an honest kind of story, a narrative about how a person is moving through their contacts here so that other workers can pick up on that at any time, and possibly people who follow us working with that person as well. Plus at the same time having a realisation that there's a possibility that these case notes could be subpoenaed and, you know, appear in the context of a person being prosecuted or in terms of child safety and those kinds of things.

Reducing harm..... Complying with expectations of statutory authorities

Jake, a 15 year old male, has been referred by the court through Youth Justice to attend AOD counselling and abstain from drug use as part of his conditional bail. Jake doesn't want to attend and knows that his Youth Justice Case Manager will be checking his attendance. Jake doesn't talk much in session. He states he has given up all that stuff... it was easy!

How do we best support and provide a health service to a young person when they feel they can't engage and be honest in a counselling session out of fear of the courts finding out?

As a health service, how can we provide harm minimisation information when the young person has been directed to abstain? How can we report back to the courts what we have provided (even though it is good practice and part of health legislation), when it is in conflict with the directives of the court?

Young person's wishes and needs..... Wishes and needs of other clients and workers

Whenever we run groups there will be instances where group and individual considerations pull you in different directions. We take a "principles approach" to running groups so we can process issues in ways that young people can learn from. But it is still hard sometimes.

At work one day there was a young man in the waiting room having a personal argument on his mobile phone, loudly swearing and shouting. This was causing other workers and young people discomfort. We wanted to engage the client and respect that he was angry and trying to argue out a situation with someone, however we also wanted to contain the behaviour and make sure that we had a safe place for other clients and service-users. We interrupted him and said that this was not ok because it was affecting other people, but then also gave him the choice to continue the conversation outside or in a private room.

The need to consider others in the community

I'd take them to the movies, a theme park, or to the beach – that sort of thing. The young people would often be really excited, but sometimes their behaviour would be very boisterous. It can be really challenging and embarrassing when you're out in public with a group when they stand out like sore thumbs and they're noisy and you're worrying if you should give up on the trip. You're concerned about working within the organisational policies and also worried about what the public are thinking. But you also know that this is how they live their day-to-day life and to expect them to be totally 'perfect' even for some of the time is fairly unrealistic.

Limitations arising from the way practice is conceptualised, undertaken and/or resourced.

The funding context, the organisational context, the particular model of service, and the service system can be experienced by workers as being in tension with the achievement of good practice outcomes.

Our organisation engages young people really well but there is a scarcity of AOD services in the community, so others want to refer to us all the time. We often get the really hard young people with really complex needs. There are limits to how well we can respond within our resources. But there is often the expectation that we will. How do we decide who we take on and who we say no to?

We are funded to provide services to young people in a particular age range. But sometimes we get a sibling group with younger ones and feel they have to be all worked with together. Other times it might be that the young person will benefit enormously if we use our connection with them to support a parent who is struggling. The funding sometimes doesn't acknowledge the full range of work we need to do and this can create real issues for us.

These are just some of the many tensions and dilemmas a practitioner may face in the course of their day-to-day work. This Guide will hopefully canvass some of the key legal, ethical and organisational considerations that can assist this practitioner to negotiate their way through these situations. Through thoughtful consideration, exploration, engagement with clients and appropriate discussion with colleagues and managers, a way forward often emerges in cases like these.

Section 2

Incorporating legal and ethical considerations into decision making

Legal and ethical considerations exist in all aspects of practice. These considerations commence from the moment a worker is employed by an organisation to fulfil a certain role. As a worker begins engaging directly with a young person, it is important that they understand and appreciate legal and ethical responsibilities that come with their role.

2.1 Understanding the nature of the professional relationship in a particular practice context

It is important to recognise that the professional practice relationship is 'bounded' which means it operates within boundaries derived from the particular role that the worker is sanctioned or mandated to undertake in particular situations.

Questions to ask in understanding your role and mandate include:

- What is the situation?
- What is my role in such a situation?
- What mandate/s do I have to practice in this situation and where is this derived from?
- What purposes, and whose purposes do I undertake practice for?
- What types of relationships do I engage in, and what are the boundaries to these?
- What power (for example discretion) do I have and how do I exercise this?

The mandate of a practitioner derives from the role or roles they are employed and/or endorsed to undertake, and how these interface with a particular practice situation. For example, are you employed as a youth alcohol and drug specialist, or are you a generalist youth worker? Are you specifically employed to provide counselling or does your role require you to do something else altogether? This mandate can change from one practice situation to another. Having a legitimate, clear and sharable understanding of your mandate for intervention is a foundation for ethical practice.

The bounded nature of this mandate means practitioners have **boundaries** within which they must practice so as to preserve the confidence and trust of those who they are working with. They practice not in their own interests, but for the benefit of others.

2.2 Key questions and considerations for decision making

The following table depicts some key questions the worker should ask when undertaking practice, as well as some of the possible considerations or tensions to be mindful of. These questions also provide a structure for the rest of this Guide.

Table 1: What does a worker need to consider in working through practice tensions?

QUESTION	POSSIBLE CONSIDERATIONS (more than one may apply)
What aspects of this situation should I be concerned about, or do I have discomfort about?	The level of autonomy and self determination to afford the young person The nature of my relationship with the young person, including boundaries My particular work role and compliance with organisational policies The need to consider the role, expectations, requirements of, and duties to, third parties: • who are part of a young person's natural network of supports and connection (e. g., parents, friends, significant others) • who have a mandated role which affects practice (e. g., the courts / youth justice or adult corrections system) • who are other service users or parties affected by what happens in practice Limitations arising from the way service delivery is conceptualised, undertaken and/or resourced within my organisation, or by other parts of the service system
What is my role and mandate in this situation?	Is this my concern? (See the section on Duty Statements, organisational policies and discussions with peers and managers) Is this only my concern? (what about clients, management and third parties?) Who else has legitimacy in this situation? (clients, managers, significant others, third parties?)
What does the law say generally about the situation? (legal information)	Criminal law (e. g., governing the young person, your professional behaviour, AOD use) Civil law (e. g., avoiding doing harm to others, law regarding negligence, anti-discrimination)

QUESTION	POSSIBLE CONSIDERATIONS
What does the law say specifically about the situation? (legal advice)	Administrative law (e. g., rights to natural justice and procedural fairness) Contract law (e. g., agreements you and your agency have entered into with others such as funding bodies or partnering organisations. This can include compliance with particular standards and delivery of specific outputs) Common law (e. g., the recognition in Queensland of young people as capable of giving consent) Do I need legal information or legal advice in order to clarify any of these as they might apply to the situation?
What does my organisation say?	Written policies and procedures Strategic and operational plans Lawful directives from management Organisationally supported training Discussions with peers and management
What does my professional framework say? **What is good practice in this situation?**	Accepted core values Professional practice standards Accepted good practice (including good youth AOD practice) Ethical issues and approaches Professional codes of ethics Ethical decision making processes
What does my personal framework say?	Personal values, boundaries and past experiences Reflective and reflexive practice Capacity to work within professional expectations in a specific situation

QUESTION	POSSIBLE CONSIDERATIONS
What impacts might my decision / approach have on my client? On others?	Ethical theories Risk assessment and management Harm reduction Inclusive approaches to decision making in direct practice
What other processes should I use to inform what I do?	Gather information / research Seek advice Consultation Inclusive decision making processes e. g., to respond to cultural and relational contexts of situation
What does my professional framework say? **What is good practice in this situation?**	Accepted core values Professional practice standards Accepted good practice (including good youth AOD practice) Ethical issues and approaches Professional codes of ethics Ethical decision making processes
On what grounds can I justify what I do?	Legal Ethical Organisational Professional Contextual Situational

Section 3

What does the law say?

3.1 The relevance of law to practice

The law is relevant to youth AOD practice in a number of ways, including:

- **Law as crime:** The illicit (illegal) nature of some alcohol and other drug use means there is a strong practice interface with youth justice and adult criminal justice systems. Young people may be charged, arrested and sentenced. Referral to AOD oriented programs or treatment may be a condition of the Court resulting in referrals to workers in those services. If not referred through courts, the illicit nature of some AOD use may mean that a young person may come into contact with police and the criminal justice system after they have become a client. When asked what they see as the legal dimensions of their practice, specialist AOD workers most commonly cite this interface with criminal justice systems.
- **Law as a resource to assist young people:** A key component of almost any work with young people involves being aware of what resources they can access and how this access can be maximised through advocacy and/or engagement with other agencies. Various laws specify access to rights and resources and conditions which might apply to this access. For example, tenancy law provides a range of protections and entitlements for people in private rental or social housing.
- **Law as duties:** Workers in health and community organisations (and the organisations themselves) are not beyond the law. There are legal expectations and provisions regarding organisational and professional behaviour and how service delivery is undertaken. Whilst there is not a great deal of legal action taken against workers and human services, these legal requirements still need to be respected.

There are also a range of core skills and competencies that workers should be conscious of. These include:

- understanding the various ways law conditions practice
- accessing legal information
- facilitating access to legal advice
- supporting young people involved in the criminal justice system or tribunal matters
- interfacing with police
- considering the legal dimensions of a practice situation or case, and incorporating these into practice processes and decision making

The following scenario helps illustrate how a range of legal considerations are important in a practice situation. It is reproduced with kind permission from the Youth Advocacy Centre.

Steven is a 15 year old boy who is staying at the Harvest Youth Shelter. He left home a couple of days before, apparently because of hassles with his stepfather. Steven is not attending school and is unable to maintain himself. The police come to the Shelter and ask to see Steven, who is out when they call. They say that he is suspected of involvement in drug related matters and search his room. They find nothing but tell Sharon, the youth worker on duty, to call them when the young person returns to the shelter.

On Steven's return, Sharon tells him the police want to see him about a drug related matter and that they searched his room. Steven says that he does have a small amount of marijuana on him, given to him by a friend, but that is all. Sharon reminds him that he should not have drugs in the shelter, so Steven gives the marijuana to Sharon. There is some drama occurring down the hallway so she puts the marijuana in the drawer of a filing cabinet in the office and locks it.

Later that evening, Steven's stepfather telephones to say that the police have said Steven is staying there, accuses the workers of "kidnapping" Steven and says that he, the stepfather is coming to get him.

Source: Wight and Hoyer 2009, 10.

Applying the question "What does the law say?" to this scenario leads to a number of important areas for the worker and service to be aware of, including:

- When can young people leave home?
- Can young people make their own decisions?
- What is the law regarding possession of an illicit drug?
- What information has to be provided to police?
- What powers do police have to search?
- What rights does the stepfather have?

For the analysis of policy and practice implications see Drilling Down 4 'The case of Steven' at the end of this Guide, where the 'answers' to this scenario are detailed. The Youth Advocacy Centre website - www.yac.net.au - also contains **a range of information sheets relevant to these questions.**

3.2 Distinguishing between legal information and legal advice

Workers should be aware that the distinction between giving legal information and giving legal advice is critically important.

Legal information – *provided where the information about the relevant law or a particular legal process is given in general terms only. It does not involve a consideration of the specific facts of the individual client's problem and an assessment of the application of the law in their case.*

Legal advice – *refers to the provision of initial one-off legal advice. This may include a referral to a more appropriate agency, but is distinguished from referral only. Legal advice relates to information given to the client that is based on a full consideration of the particular facts in their case and an assessment of whether, or how, the law might apply in the particular case.*

Source: Caxton Legal Centre, personal communication.

It is vital that practitioners who are not legally qualified understand that they should not give legal advice. Even supplying general information about the law can be quite involved. Workers should only use sources of legal information that are relevant and up to date, whilst also remembering that some laws around AOD use are contained in State legislation and some in Commonwealth legislation.

It is also strongly recommended that workers provide a clear explanation or warning when supplying legal information or resources to someone. The general warnings following are adapted from *The Queensland Law Handbook*, 2011, published by Caxton Legal Centre.

'The information provided by this service and workers is general legal information, not legal advice, and accordingly must not be relied upon or applied by anybody to their own case. Young people must be advised that each set of circumstances needs to be looked at individually and they must seek individual legal advice if they have a legal problem'.

'The information provided in _____ is for information only. It must not be relied on as legal advice. You should seek legal advice about your own particular circumstances'.

So what legal information might a worker give a young person? Depending on the context workers might share information about laws that relate to AOD use, income support, housing and tenancy, mental health, policing and court processes just to mention a few. How a worker phrases this and how a young person understands the meaning is also very important to consider.

For example a worker could say:

"In Queensland there are laws which give certain rights to people who rent" (but **NOT:** "That landlord can't do that to you - that's illegal").

Even giving a young person some general legal information could be interpreted by them as giving advice, so workers should be cautious in what is quite a complex area. Having ongoing links to legal and advocacy services will assist workers and services to develop and maintain appropriate legal information giving strategies.

It is **NEVER** appropriate for a worker to advise a young person to plead guilty to an offence, even if you thought that this would be in their best interests. However it would be appropriate for a worker to encourage and assist a young person to contact a legal service or lawyer to discuss their options and to then check with that young person that they fully understand those options and their consequences.

If the worker or a young person is not clear about what they should or should not do in a particular situation or set of circumstances, then they will need to obtain some legal advice.

Source: Wight and Hoyer, 2009, 7.

3.3 Where to access legal information and legal advice

Legal information on specific topics is available from a wide range of sources including the websites of various legal services. Some sites and services offer legal information specifically oriented to young people.

Legal advice can be sought from legal practitioners located at legal firms, Community Legal Centres, Legal Aid Queensland, the Public Trustee, the Queensland Law Society, Alternative Dispute Resolution (ADR) services, advocacy services with a particular focus (e. g., the Tenants' Union of Queensland) and the Dispute Resolution Centre.

Contact details for a number of organisations which provide legal information and advice are listed in the following table.

Table 2: Where to access legal information and advice

ORGANISATION	SERVICES	CONTACT DETAILS
Aboriginal and Torres Strait Islander Legal Service (ATSILS)	Provision of legal representation to Aboriginal and Torres Strait Islander people in criminal, civil and family law; prison based advice; advocacy	www.atsils.com.au (07) 3025 3888 1800 012 255
Queensland Association of Independent Legal Services (QAILS)	If you need advice about a specific legal problem the QAILS website's 'find free advice' page has links to a wide range of options and services including the various community legal centres (CLC's) across Queensland	www.qails.org.au (07) 3392 0092
Youth Advocacy Centre	A youth specific confidential legal and welfare assistance service based in Brisbane for young people 12-17 years	www.yac.net.au www.facebook.com/yacbrisbane www.twitter.com/yac196 (07) 3356 1002
Logan Youth Legal Centre	A youth specific CLC for young people under 18 years in the Logan City area.	www.yfs.org.au (07) 3826 1599
Legal Aid Queensland	Provides advice about specific legal problems	www.legalaid.qld.gov.au 1300 65 11 88
Queensland Public Interest Law Clearinghouse (QPILCH)	Provides information on pro bono legal assistance	www.qpilch.org.au (07) 3846 6317
Caxton Legal Centre	A CLC providing a wide range of services. Publishes The Queensland Law Handbook and other legal books and self-help kits	www.caxton.org.au (07) 3214 6333
Tenants' Union of Queensland	Provides free tenancy law advice	www.tuq.org.au 1300 744 263

ORGANISATION	SERVICES	CONTACT DETAILS
Welfare Rights Centre	Provides free advice on matters relating to Centrelink and welfare entitlements, and a Disability Discrimination Legal Advocacy Service for disability discrimination in the workplace	www.wrcqld.org.au (07) 3847 5532 1800 358 511 (only for outside Brisbane)
Refugee and Immigration Legal Service (RAILS)	Provides free legal assistance in immigration and refugee cases to people in need	www.rails.org.au (07) 3846 3189
Women's Legal Service (WLS)	A specialist community legal service run by and for women. Free legal information, advice and referrals throughout Qld	www.wlsq.org.au (07) 3392 0670 (advice line) 1800 677 278 (freecall outside Brisbane) 1800 457 117 (rural, regional and remote)
LGBTI Legal Service	Provides free legal advice, assistance and referral to Lesbian Gay Bisexual Transgender and Intersex communities	www.lgbtilegalservice.org 0401 936 232
Dispute Resolution Centres	Assists with facilitating dispute resolution and with mediation services e. g., with neighbours, at work, and in criminal justice processes	www.justice.qld.gov.au
Youth Workers and ther Law (Linked In Group)	Engage with YAC and other youth workers around QLD to discuss issues around "Youth Workers and the Law"	www.linkedin.com Groups: "Youth Workers and the Law"

3.4 Young people and the law regarding alcohol and other drugs

There are two specific Acts which regulate the production, possession and supply of illicit substances in Queensland. These are:

1. the *Criminal Code Act* 1995 (Cth) (Cth Code)
2. the *Drugs Misuse Act* 1986 (Qld)

Specific offence categories most relevant to workers with young people in respect of illicit drugs pertain to:

- trafficking dangerous drugs,
- supplying dangerous drugs,
- receiving / possessing property obtained from trafficking or supplying dangerous drugs,
- producing dangerous drugs,
- publishing or possessing instructions for producing dangerous drugs,
- possessing dangerous drugs,
- possessing, supplying and producing relevant substances or things such as chemicals and apparatus used to manufacture dangerous drugs,
- possessing things used in connection with a crime involving dangerous drugs,
- possessing certain property reasonably suspected of having been used or involved in the commission of some drug related offences,
- possessing prohibited combinations of certain items (e. g., chemicals commonly used to manufacture dangerous drugs),
- permitting premises to be used for drug offences.

Source: Carter in The Queensland law handbook, 2011. 538.

For further information *The Queensland law handbook* (2011) published by the Caxton Legal Centre provides an overview of criminal law regarding drugs (535-545).

Legal information for young people on 'Alcohol and Drugs'

Youth Advocacy Centre

NB: The Youth Advocacy Centre does not accept responsibility for any action arising out of reliance on this information. This legal information is relevant to Queensland, Australia. This is intended to provide general information only, not advice. If you have a particular legal problem you should contact a solicitor.

When can I drink or buy alcohol?

It is against the law for a person under 18 to buy alcohol. You can be asked to show ID to prove you are 18 before someone sells you alcohol. It is an offence to:

- pretend to be 18 to try to get alcohol,
- fake an ID,
- change an ID to make you look 18.

Can I drink alcohol when I am at home?

If you are under 18 then a responsible adult can only supply you alcohol if you are on private premises AND the adult is responsibly supervising you. To decide if you are being responsibly supervised the factors that can be considered are:

- whether the adult or you are drinking or drunk,
- how old you are,
- whether the adult or you have eaten,
- whether the adult is with you and checking on how much you are drinking and what effect it is having on you,
- how much alcohol you are drinking over what period of time.

A responsible adult means your parent, step-parent, guardian or an adult who has parental rights and responsibility for you. The adult can be fined if they are not supervising you responsibly and the police can also confiscate (take and dispose of) the alcohol.

Can I drink in a public place?

If you are under 18 you are not allowed to drink alcohol in a public place. Generally no-one can drink in a public place unless there is a sign which says they can (for example, certain places at South Bank in Brisbane). However, people under 18 are not allowed to drink alcohol even in those areas. A public place includes cinemas, shopping centres, malls, buses, parks or the street. If you are under 18 you cannot carry alcohol in public. This includes carrying it for your friends or parents. It does not matter whether the alcohol is sealed or open.

Can I be picked up for being drunk?

Yes. It is an offence to be drunk in a public place (no matter what your age). Using obscene or insulting language or behaving violently, disorderly or indecently is also an offence. These offences are called public nuisance offences.

When can I start smoking cigarettes?

There is no law that says when you can or can't smoke cigarettes BUT it is against the law for an adult other than your parent or guardian to sell or give you cigarettes if you are under 18. Shopkeepers can ask to see ID to prove you are 18. If someone like a police officer sees you being sold or given cigarettes and they ask for your name, age and address, you must tell them or you will be breaking the law. They can take the cigarettes away for evidence against the person who sold / gave them to you and they do not have to give them back to you.

When can I be charged with a drug offence?

You can be charged with a drug offence if you:

- have possession of a dangerous drug (including marijuana, heroin, cocaine, LSD, ecstasy or speed);
- have possession of property (other than a syringe or needle – if stored / disposed of properly – see below for how to store or dispose of syringes and needles), which police believe is to be used to commit a drug offence. This can include having a bong or a pipe on you, as well as scales or scissors;
- supply a dangerous drug (give, sell, deliver a drug to someone else or offer to do any of these);
- produce a dangerous drug (grow, prepare or package a dangerous drug or offer to do any of these);
- are the occupier of a place and you allow it to be used for drug offences. This is important for people in share accommodation who know housemates or friends of housemates are using drugs on the property. Instead of the police having to prove you knew that drugs were on your property you will have to prove that you didn't know there were drugs on your property;
- are trafficking a dangerous drug (dealing, carrying on a business even if you do not make a profit).

The sentence for these offences will depend on the drug and how much there is of it. If you are charged with producing or possessing heroin or cocaine and you can prove you are drug-dependent the court will take this into account when sentencing you.

Can I be sent to the drug diversion assessment program instead of going to court?

Yes. You can be sent to a drug diversion assessment program if:

- you have been charged with possession of marijuana and the amount is less than 50g; OR
- you have been charged with possession of a thing that is to be or was used in connection with the smoking of marijuana, AND
- you have not been charged with any other offence to do with the above charge; AND
- you have told the police in a record of interview which is recorded electronically that you did have the marijuana or the thing; AND
- you have not been to the drug diversion assessment program before or the police have not offered to send you there in the past.

What does "possession" mean?

You can be charged with "possession" if:

- you have the drugs on you, in your pocket or room (even for a very short time);
- in a school locker where you have the only key;
- in a bag that you give to a friend;
- you try and hide drugs to protect a friend when the police are about to search a room.

More than one person can be "in possession" of drugs at the same time. For example, if a number of people in a room are smoking marijuana, they may all be "in possession" of the drug being smoked or the thing being used to smoke it. It is not just the person who is actually using it when the police arrive that could be charged.

Is it illegal to carry needles or syringes on me?

No. It is not an offence to carry needles or syringes on you either:

- clean (but they must be carried safely); OR
- used (they must be in a "puncture proof, hard, resealable container" and if the police "trace test" them you can be charged with "possession" of the drug that may be left in them).

Remember you do not have to answer any questions, except you must give your correct name, age and address. If you admit to using and have a used fit on you, the police can use this in gathering evidence against you.

What about a sharps container?

It is not against the law to have a sharps container (disposal unit issued by the Health Department) - only the drug in the used fits or dirty syringe is illegal. You must dispose of your fits in a "puncture proof, hard, resealable container" (the disposal unit from the Health Department or another unit like a Milo tin) and then in a garbage bag in the rubbish or return them back to the needle exchange. Any other way of disposal is illegal and you could be charged.

Can the police search me if they suspect I have drugs on me?

Yes.

Can a police officer take away things I am using to inhale?

Yes. If a police officer believes that you are using an inhalant or about to use an inhalant (chroming) then the police can take away whatever you are using to do this. It does not matter if it is not something illegal. For example if you have some glue. It is not an offence to have the glue.

The police only have the power to take it away from you and you cannot get it back. The police officer can ask you if you have a reason for having the substance. If you do have a good reason (for example you have some glue because your parents asked you to buy it) then the police can allow you to keep it. The police will decide whether you can keep it. You should also remember not to mislead or lie to the police because you could be charged with obstructing police.

Can police take me to a safe place if I am drunk or have been inhaling or ingesting (chroming) volatile substances?

Yes, the police can take you to a safe place. A safe place is a place where you can receive treatment or care to allow you to recover. For example; your home, a hospital or a place which is set up to help you recover from chroming. A police station is NOT a safe place under this law.

What information do I have to tell the police when stopped on the street?

You do not have to answer any question the police ask you even if you are arrested. BUT you should give your correct name, address and age, as it is an offence not to do this. Be aware that anything you say (even on the streets) may be recorded without you knowing.

Also at special events a security officer might be authorised with similar powers to police and may be able to require you to give your name and address. But usually they must first present their identity card to you. Ask if they do not show you their identity card.

Source: This information has been reproduced with kind permission from The Youth Advocacy Centre. You can check for updates on this information (and access other information on various topics) from www.yac.net.au

Legal information on 'Driving, Alcohol and Drugs'

Youth Advocacy Centre

NB: The Youth Advocacy Centre does not accept responsibility for any action arising out of reliance on this information. This legal information is relevant to Queensland, Australia. This is intended to provide general information only, not advice. If you have a particular legal problem you should contact a solicitor.

What is a vehicle?

A vehicle is any type of transport with wheels and includes a motor vehicle, bicycle and a "wheeled recreational device" [rollerblades, rollerskates, skateboard, and scooter with or without an electric motor]).

What is a motor vehicle?

Motor vehicles are cars, motorbikes, jetskis, any other vehicles with an engine and include boats.

What if I am driving and I have been drinking or taking drugs?

It is an offence for to you have any alcohol at all and drive or attempt to drive a motor vehicle if you are a learner (on L Plates) or a person on P Plates as your blood-alcohol level cannot be higher than 0.00. (When you are off your P plates, the limit is generally 0.05 but there are exceptions: for example, if driving is your job; or if you are on a probationary licence following your driver's licence being suspended.)

It is also an offence to drive, attempt to drive, or to be "in charge" of a motor vehicle anywhere if you are affected by alcohol, illegal drugs, or legal drugs which a doctor has prescribed for you. For any other type of vehicle it is an offence if you are on a road – however, "road" doesn't just mean the street.

So, it would be an offence to be "under the influence" of (affected by) drugs or alcohol and have your skateboard at the local shopping centre car park but this would not be the case if you were on the grassed area of the local park. (In either case, however, you could still be picked up for being drunk in a public place.)

What does being "in charge" of a motor vehicle mean?

Being "in charge" of a motor vehicle can include having the keys to a car or being the only person in the car even though the engine isn't running. Being asleep in the back of a parked car can be enough for police to charge you if the police breath test you and you are over the limit that applies to you.

(It is also an offence to be affected by alcohol and be in charge of certain types of animal (including a horse or dog) on a road.)

When can the police ask for a breathalyser / breath test?

A police officer can stop you and ask you to take a breath test if:

- you are driving or attempting to drive a motor vehicle (car, motorbike, jetski, any other vehicle with an engine or a boat); or
- you are the person who seems to be "in charge" of the motor vehicle; or
- the police officer believes that, during the three hours before asking you to take the breath test, you drove or attempted to drive a motor vehicle or were in charge of a motor vehicle); or
- the motor vehicle has been involved in an accident and the police officer believes you were the driver or person in charge.

For any vehicle (so including bicycles, rollerblades, rollerskates, skateboards, and scooters), if a police officer has arrested you because they think that you are affected by alcohol – for example because of the way you are driving or riding – they can ask you to take a breath test.

Can I refuse to take a breath test?

It is an offence to refuse to take a breath test. If the police want to breath test you in relation to a motor vehicle, you may also be charged with a more serious drink driving offence even though you may not have had any alcohol at all.

The police officer can take you to the nearest police station - by using reasonable force if necessary.

What about saliva, blood or urine tests?

There are similar laws for saliva tests for drugs and driving as for breath tests.

You could also be asked to take a blood or a urine test if the police think your behaviour shows you are affected by alcohol or drugs but the levels of the breath or saliva tests you took were low or nil. You can be charged with an offence if you refuse to take these tests.

What will happen if the police think I have been drinking or taking drugs?

If the police believe you were driving, attempting to drive or were "in charge" of any vehicle when affected by alcohol or drugs; or you have an alcohol limit above what applies to you for a motor vehicle, then:

- you can be arrested, taken to the police station and have to go to court;
- if found guilty, you can be given a fine or another sentence.

If you are found guilty of offences involving a motor vehicle:

- your licence can be cancelled; and
- you can be disqualified from holding a licence for a certain amount of time.

Source: This information has been reproduced with kind permission from The Youth Advocacy Centre. You can check for updates on this information (and access other information on various topics) from www.yac.net.au

3.5 Supporting young people in the court process

There are various ways that practitioners who work with young people experiencing problematic AOD use may come into contact with courts and tribunals. These are too numerous to canvas here. The various courts and tribunals relevant for Queensland, including the Drug Court and various diversion programs, are detailed in 'Drilling Down 3'.

As a general statement youth workers and youth AOD specialists can play an important role in assisting and supporting young people in their engagement with courts and the criminal justice system more broadly. Young people can experience the court process as fast and confusing. The Youth Advocacy Centre publication 'Laying Down the Criminal Law' (Wight and Hoyer 2009, 98-102) has an excellent outline of what a worker supporting a young person through the court process can do before, during and after a court appearance.

Table 3: Supporting young people in the Childrens Court youth justice process

WHEN	WHAT A YOUTH WORKER CAN DO
Pre-court	• Assist the young person to seek legal advice from a solicitor as soon as possible prior to being interviewed by police and for any court appearance (e. g., from a Community Legal Centre or Legal Aid Queensland). • Remember, most courts have Duty Solicitors if needed. • Ensure the young person knows when and where they are required to be at court. • Provide transport if necessary and appropriate. • Explain the pre-court interview process and roles played by each person in the court (Court Services Officer, Solicitor, Police Prosecutor, Magistrate). • Ensure the young person understands the notion of giving 'instructions' and the consequences of their instructions. • Duty Lawyers at Court have limited time. Assist the young person to make themselves known to the Duty Lawyer and afterwards check that the young person understands what will happen in Court. If they don't fully understand the situation, assist the young person to see the Solicitor again. • With the young person's consent assist the Duty Lawyer with background information for making submissions to the Court and for bail applications. Assisting a young person who is homeless to access accommodation to ensure bail is especially useful.
During Court	• Present well and treat the process with respect. • Provide support in Court, especially if the young person has no other support networks attending. • Gain permission from the young person to go into Court. Children's Court is a closed Court and permission is required before entry will be granted. • Where a young person has either pleaded or been found guilty and is being sentenced, a brief report can be provided by a worker to assist the Court to more fully understand the young person's individual circumstances and views.

WHEN	WHAT A YOUTH WORKER CAN DO
During Court	• Written reports should be succinct and have the full endorsement of the young person and their solicitor. It should contain a reflection of what the young person wants the Court to know; the workers' role, qualifications and experience, and length of time they have had with the young person; the young person's circumstances at the time of the alleged offence; their present situation; positive information about the young person that is relevant; and any support or further work that will be undertaken with the young person. • Remember, a worker can be asked questions which challenge information they have provided, and be asked to verify or expand on this information.
Post court	• Check that the young person understands the outcome of the court appearance. • Assist them to gain further legal representation if required. • Provide follow up support and referral options (e. g., addressing AOD issues, accommodation), mindful of any involvement the Department of Communities may now have post court.

Source: Wight and Hoyer 2009, 98-102.

The written information workers may be required (or have the opportunity) to furnish the court can range from attendance statements and letters of support, to comprehensive reports detailing a client's personal circumstances and treatment history. Various government and non-government websites provide advice on giving information to courts, some specifically oriented to a particular type of court or type of report. Some organisations have a particular template or format that they use when compiling reports for courts.

Importantly, this Guide does not recommend that workers freely hand over client records, charts, letters of attendance or a specific court report to anyone until they have:

- their client's consent,
- their manager's review and authorisation.

Some useful questions to consider when writing a court report are outlined in the Shopfront Youth Legal Centre: "Preparing a Court Report" factsheet at: www.theshopfront.org

See 'Drilling Down 2' for important background information on the types of law in Australia and the various courts and tribunals for Queensland and Australia.

Section 4

Legal considerations and concepts relevant to practice with young people

The purpose of this section is not to scare or to promote defensive, risk-averse practice. Rather it is so that practitioners and services can apply principles that may help their clients and themselves avoid negative legal sanction, whilst also being able to use the law as a resource for achieving positive practice outcomes.

Whilst some aspects of the law are clear, in relation to frontline practice with young people around AOD use the law can be quite 'grey', what Braye and Preston-Shoot (1997, 51) refer to as the 'myth of clarity'.

Keep in mind there are blurry edges to the application of most legal terms and that there have not been very many cases go to court for determination in respect of human services practice.

4.1 Some relevant legal principles for practice

Young people have a range of rights which have a basis in law. Some which regularly have relevance to practice with young people are:

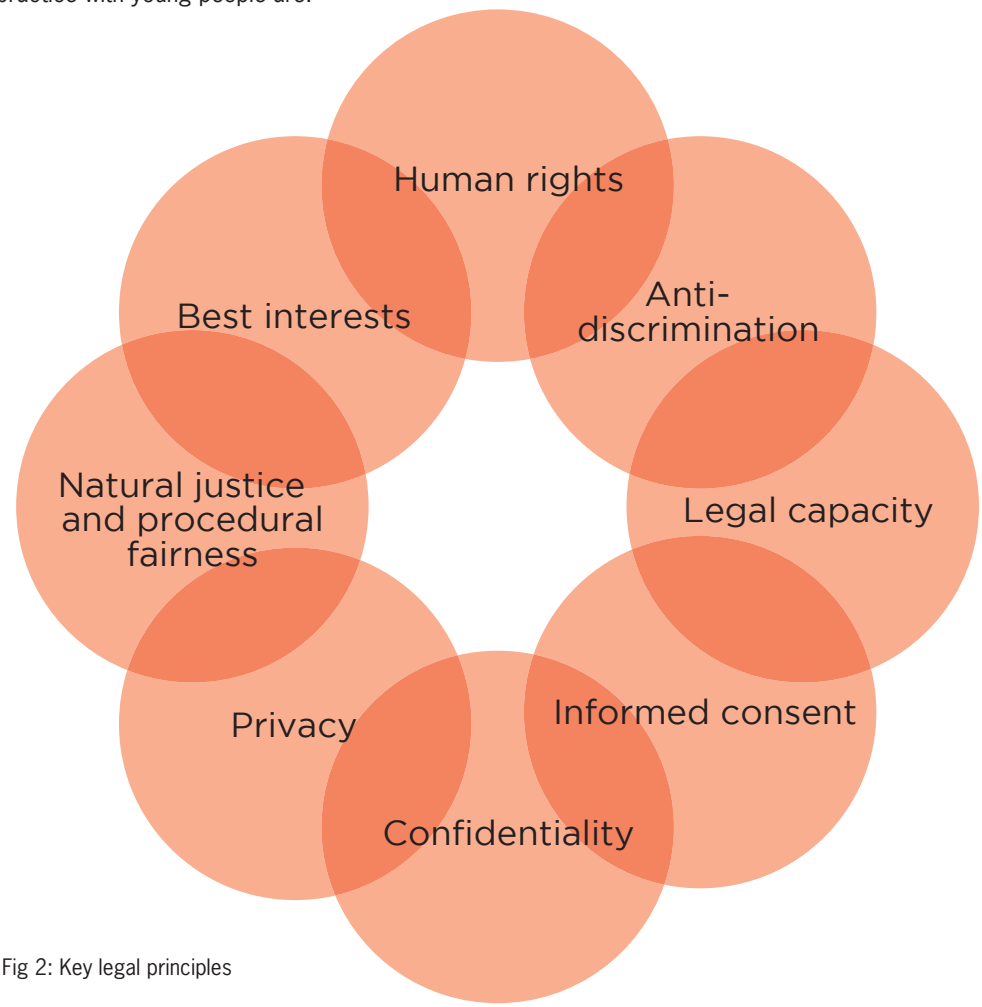

Fig 2: Key legal principles

4.1.1. Human rights

Australia is a signatory to various United Nations conventions and treaties. Courts may use these in interpreting legislation and human rights may be used to provide a base for, or to orient legislation. Human rights principles can also be used to inform policy regarding health and welfare service delivery and evaluation.

In respect of young people, Australia is a signatory to the Convention on the Rights of the Child (CRC), which in turn is acknowledged in various statutes and policies.

[CRC] … spells out the basic human rights that children everywhere have: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. The four core principles of the Convention are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. Every right spelled out in the Convention is inherent to the human dignity and harmonious development of every child. The Convention protects children's rights by setting standards in health care; education; and legal, civil and social services.

Source: United Nations. 1989. UN Convention on the rights of the child. [www.unicef.org/crc/]

The CRC and other human rights instruments which Australia recognises can be found on various websites including:

- www.dfat.gov.au/hr
- www.ag.gov.au

4.1.2 Anti-discrimination

The term 'discrimination' is a legal one defined by relevant legislation and there are anti-discrimination laws at both Federal and State levels. At the Federal level, laws prohibit:

- race discrimination,
- sex discrimination,
- age discrimination,
- discrimination on the basis of sexuality,
- disability discrimination.

The Australian Human Rights Commission website at www.hreoc.gov.au provides a range of information and resources.

In Queensland the *Anti-Discrimination Act* 1991 prohibits direct and indirect discrimination on various grounds, sets out offences, and states how complaints can be made. Age is one prohibited ground for discrimination. Good youth AOD services should ensure they deliver services in ways that are not discriminatory. For example, Section 46 of the *Anti-Discrimination Act* prohibits discrimination in the provision of goods and services. Whilst there are various exceptions to these provisions, workers may find this provision useful when advocating for a young person in some situations.

The Anti-Discrimination Commission of Queensland website is www.adcq.qld.gov.au

4.1.3 Legal capacity

Some aspects of practice require workers to consider whether the young person has legal capacity. Legal Aid Queensland defines legal capacity in the following way:

Legal capacity is the ability to make binding legal arrangements, sue and make other decisions of a legal nature. It is linked to whether you have the mental capacity to understand the significance of what you are doing. Legal capacity is assessed for every situation separately, and you may have capacity to make some legal arrangements and not others.

Do children have legal capacity?

The parents of children under 18 are their legal guardians. This means they have responsibility for the long term wellbeing of the children such as responsibility for decisions about their religion and schooling.

In many situations parents are required to sign on behalf of children under 18. In some situations children do have legal capacity to act on their own behalf. If they have sufficient understanding of the significance of what they are doing, they may make a binding contract for the necessities of life or they may make decisions about their own medical treatment if they understand its significance.

Each legal situation needs to be assessed on its own merits and you should get legal advice.

Source: Legal Aid Queensland. 2012. " Do children have legal capacity to make a binding contract?" [www.legalaid.qld.gov.au]

Parents have a legal responsibility to care for, protect, guide and provide for their children to adulthood, and the right to decide on day to day issues that might affect them (e. g., where their children live, where they go to school, seeking medical treatment, religious education etc.) unless a court order exists which alters this (Queensland Government Department of Communities, November 2008, 7). Whilst parents have such responsibilities, their children also have the right to be heard and to participate in decision making on matters that affect their interests, taking their capacity to understand these issues into account (Alston and Brennan, 1991).

There are a variety of ways in which the concept of legal capacity might be relevant to youth AOD practice. For example:

A young male client with a diagnosed mental illness signed a contract with a "payday" lender. It was a complex contract with exorbitant compound interest. At the time of signing the contract the young person was in an episode of mania consistent with their diagnosis of bi-polar disorder. The question for me was, did my client have 'legal capacity' when he signed this loan contract?

Frontline youth worker

In this case, it is entirely possible that the young person did not have legal capacity to sign the contract, although this could only be determined by a court of law in light of all facts and circumstances.

4.1.4 Informed consent

Understanding the notion of "informed consent" is important for all practitioners, especially those working with young people. Informed consent requires that:

- the client has full information about the intervention or disclosure procedure and its risks generally, and to them specifically;
- consent is both intervention or activity-specific and time-limited;
- information is presented in a form that can be comprehended by the client, and the client has an opportunity to clarify it;
- the client has comprehended the information;
- the client has genuinely consented to the activity, preferably in writing;
- the worker records their actions in giving information, eliciting and answering questions, and in obtaining consent.

Source: Kennedy with Richards 2007, 88.

Other generally valid considerations (Kennedy 2009, p191-193 citing Reamer 2003) suggest that consent is:

- not given under circumstances of coercion or undue influence.
- premised on the right to withdraw.
- based on comprehensive information about who will do what, when and why, risks, side effects and possible outcomes. A process of encouraging client questions strengthens evidence that consent is informed.
- in valid form … particular Acts may impose specific requirements.
- given by someone with the necessary mental capacity.

Keep in mind:

- General consent forms, particularly those which relate to a range of activities, provide very little legal protection in a court of law.
- Workers engaged in direct client support and advocacy work should discuss with their clients the possible positive AND negative outcomes of their strategies. For example, that their intervention could delay a decision, allow penalties to increase, result in possible financial costs or gain closer scrutiny of their affairs.
- Gaining informed consent is more complex when an individual may have limited competence or capacity to understand a situation or its consequences.
- Practitioners should always consider whether they need to discuss the requirements for informed consent with their clients, their supervisors and other appropriate people.

Informed consent and young people

The National Children's and Youth Law Centre paper on Counsellors and their Child Clients (2004, 3) cites three key legal issues in the relationship of non-medically qualified providers of counselling with children, these being:

- whether children have the legal capacity to enter a client relationship with the counsellor independently of their parents. The paper concludes that the law recognises the capacity of 'mature' children to consent to counselling and to undergo counselling of their own volition.
- whether children are owed a duty of confidentiality analogous to adults, so that counsellors would be in breach of their duty if they informed parents that their child is being counselled or of the contents of the counselling session. The paper concludes that the law may recognise that children who are capable of consenting to a confidential relationship are owed a duty of confidentiality by counsellors.
- whether parents have the authority to force an unwilling child to undertake counselling. Despite English cases that have held to the contrary, the paper suggests that Australian law would accept that parents are unable to force an unwilling child to counselling. Possibilities for reform are suggested to improve certainty in the law and to educate counsellors, children and their parents, of the obligations of confidentiality owed by counsellors to their child clients.

Source: National Children's and Youth Law Centre. 2004. Counsellors and their child clients. 3.

The common law position in Australia and Queensland for working with young people under 18 without parental consent derives from 2 important cases, the UK case Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112 (Gillick case) and the Australian case Secretary, Department of Health and Community Services (NT) v JWB and SMB (1992) 175 CLR 218 (Marion's Case). These affirm that subject to 'maturity', a medical practitioner may respect the capacity of a minor (a young person under 18) to make their own medical decisions (Teoludzka and Bartholomew 2010). Hence the terminology of 'mature minor' and 'Gillick competency'.

An older child is competent to provide his or her own consent to treatment if he or she has sufficient understanding and intelligence to fully understand the treatment.

However a court may override such a child's consent (or refusal of treatment) if the proposed treatment (or refusal) is deemed not to be in the child's best interests.

Source: Matthews 2010, 114.

The Queensland Health (2012) Guide to Informed Consent in Health Care reflects this position. Note that in this report 'health care' is defined more narrowly in terms of medical treatment. The Guide is available at www.health.qld.gov.au

In Queensland there is no fixed lower limit below 18 years of age at which children or young persons are deemed to be able to consent to healthcare, and so, as they mature, the child's capacity to consent generally increases. On the other hand, the authority of parents to consent on behalf of a child or young person is not absolute. Their parental responsibility decreases as the young person matures until it ceases to exist when the child reaches 18 years of age. As a result of this there may be times when both someone with parental responsibility and the child or young person simultaneously have the ability to provide consent to healthcare.

If the child or young person has sufficient capacity to consent and does so, this is usually sufficient for giving routine medical/dental treatment, including contraceptive advice, without the need for parental consent. However, even though a child or young person may have capacity to consent on their own, it is good practice to encourage them to consider seeking the involvement of a parent or other adult of their choosing before reaching a decision.

If a child or young person does not wish to involve a parent or other adult, the reasons for this are explored.

If the child or young person has sufficient capacity to make a decision not to involve an adult, their wishes usually need to be respected, but may be overruled in some circumstances, for example, when there are potential child protection concerns arising from a pregnancy or a sexually transmitted infection.

Source: Queensland Health. 2012. Guide to informed consent in health care, 35.

The Youth Advocacy Centre (Wight and Hoyer 2009, 80-82) outlines the application of the *Gillick Case* to the broader field of youth work in the following way:

- The *Gillick Case* applies to any adult who works with a young person.
- The reasoning recognises a child's increasing ability to make decisions about their lives.
- The essence of the **Gillick test** for whether a young person can make their own decision is whether "a young person can understand the physical, emotional and spiritual consequences of their decisions both in the short term and long term" (ibid, 81).
- This involves using appropriate techniques to check whether a young person has understood the consequences.

The developmental logic underpinning Gillick Competency resonates with practitioner concerns about how much autonomy they should afford 'younger' young people. It is important to also appreciate that **practice with young people occurs in the broad context of Australia's commitment to the UN Convention on the Rights of the Child** which affirms the right of children to participate and be heard in respect of decisions affecting them, and that any decisions made about them should be in their 'best interests'. As with other legal and ethical considerations, practitioners should seek support and advice if they are unclear. Services should encourage discussion between practitioners and supervisors regarding how the competency of young people should be approached.

Assessing capacity to give informed consent

There are a number of aspects to assessing a young person's capacity to give informed consent. These flow from the common law position established by the Gillick case. The Queensland Health guide on informed decision-making (2012) provides the following information to health care professionals:

To establish that a child or young person has capacity to consent to healthcare, the health practitioner can carry out an assessment to show the patient has sufficient understanding, intelligence and maturity to appreciate the nature, consequences and risks of the proposed healthcare, and the alternatives, including the consequences of not receiving the healthcare.

When assessing a child or young person's capacity, the following issues should be considered:

- *the age, attitude and maturity of the child or young person, including their physical and emotional development;*
- *the child or young person's level of intelligence and education;*
- *the child or young person's social circumstances and social history;*
- *the nature of the child or young person's condition;*
- *the complexity of the proposed healthcare, including the need for follow up or supervision after the healthcare;*
- *the seriousness of the risks associated with the healthcare;*
- *the consequences if the child or young person does not have the healthcare;*
- *where the consequences of receiving the healthcare include death or permanent disability, that the child or young person understands the permanence of death or disability and the profound nature of the decision he or she is making.*

Source: Queensland Health. 2012. Guide to informed decision-making in healthcare. 40.

Whilst each young person and situation must be assessed individually, the Queensland Health Guide suggests the following broad guidance in respect of age:

Maturity and intellectual development varies from one individual to another and an assessment of a child or young person's capacity is performed for each new healthcare decision. However, as a practical rule of thumb:

- *a young person aged between 16 and 18 is most likely able to consent*
- *a young person aged between 14 and 16 is reasonably likely to be able consent*
- *a child under the age of 14 may not have the capacity to consent, except for healthcare that does not carry significant risk*

Source: Queensland Health. 2012. Guide to informed decision-making in healthcare. 40.

The Fraser Guidelines, developed in the UK following the Gillick case, have also been used as a checklist of questions for practitioners to use in determining the capacity of a young person in a particular situation.

Checklist of questions to consider when assessing Gillick Competence (also known as the 'Fraser Guidelines'):

1. Has the young person explicitly requested that you do not tell their parents / carers about the services that they are receiving?
2. Have you done everything you can to persuade the young person to involve their parent(s) / carer(s)?
3. Have you documented clearly why the young person does not want you to inform their parent(s) / carer(s)?
4. Can the young person understand the advice / information they have been given and have sufficient maturity to understand what is involved and what the implications are? Can they comprehend and retain information relating to your service, especially the consequences of having or not having accessed the services in question? Can they communicate their decision and reasons for it? Is this a rational decision based on their own religious belief or value system? Is the young person making the decision based on a perception of reality?
5. Are you confident that the young person is making the decision for themselves and not being coerced or influenced by another person?
6. Are you confident that you are safeguarding and promoting the welfare of the young person?
7. Without the service(s), would the young person's physical or emotional health be likely to suffer? (if applicable)
8. Would the young person's best interests require that the identified services and support be provided without parental consent?

You should be able to answer YES to these questions to enable you to determine that you believe the young person is competent to make their own decisions about consenting to and taking part in the service without their parent's consent.

Source: Adapted from Fraser guidelines/Gillick competency checklist. 2009. [www.doncaster.gov.au]

Practitioners should fully document in the young person's file or record the assessment they have carried out, including the details that influenced their decision as to whether the child has capacity (Queensland Health 2012, 40).

Other important considerations raised in the Queensland Health Guide and other sources include:

- The more complex the intervention or more serious the consequences, the stronger the evidence of the child or young person's capacity to consent to the specific intervention will need to be.
- A child or young person who has the capacity to consent to a low risk intervention may not have capacity to give consent to a major intervention with greater risks and more serious consequences.
- A child or young person who is intellectually disabled may still be capable of consenting to and possibly refusing intervention depending on the specific circumstances.
- Where a child or young person does not have capacity to give consent, this does not reduce the significance of their involvement in decision-making, and practitioners should communicate with them and involve them as much as possible in decisions about their care.

Practitioners working with young people whose AOD use is problematic can often be in this terrain of 'more complex and serious' circumstances. It is important to appreciate that assessing a young person's competency to make decisions is not a one-off event but instead needs to be revisited as circumstances change and new issues arise. A young person may be Gillick competent in respect of some decisions and interventions but not others.

In terms of **research involvement** the Australian National Health and Medical Research Council (NHMRC) in the *National statement on ethical conduct in human research*, 2007, recognises that young people under 16 years are capable of being seen as 'mature minors' and can therefore give consent to participate in research.

4.1.5 Confidentiality

If the worker considers the young person to be Gillick Competent then they should afford that young person confidentiality in the absence of specific laws that require disclosure (Wight and Hoyer 2009, 82).

Confidentiality is also sometimes referred to as information privacy. Confidentiality in a health service context can be defined as the right of a client to ensure all of the information relating to their health care is not shared with other parties without their permission (*Public Health Act* 1991, *Health Records and Information Privacy Act* 2002, *Privacy Act* 1988).

There is strong evidence that concern about confidentiality, particularly whether parents will be informed, is a factor limiting young people's access to needed health care (English and Ford 2007, Lehrer et al. 2007).

Concerns about privacy can influence adolescents' use of health care by leading them to delay seeking care or to forego care entirely (Ford et al. 1999), affect their choice of provider (Sugerman et al. 2000, Lane et al. 1999), their candor in responding to questions about sensitive topics (Ford et al. 1997), and their acceptance of certain interventions (English and Ford 2007, 199).

The following scenario highlights a common concern of workers: how to respect confidentiality and its limits when engaging with parents and legal guardians. The worker's response needs to not only respect the legal basis for confidentiality, but utilise practice that reflects organisational policy and good practice processes, such as working to strengthen important relationships.

Sandra is the mother of Mark (15 years old) who is attending a youth counselling service. On the telephone Sandra is angry and demands to know if Mark attended and what drugs he is using. "He is my son and I have a right to be told".

The counsellor listens to Sandra's concerns and reflects back her distress. "I understand this is a really difficult time and that you are upset and want to know what is going on". The counsellor defines the service role, trying to manage her distress and resistance. "This service provides alcohol and other drug counselling. We try to help young people be safer and work towards positive goals, and always encourage young people to include their family in treatment here".

Sandra's level of distress decreases. The counsellor maintains confidentiality. "I wish I could let you know if he attended or what he may say. But if I do this without his consent I think he would be angry with you and me and stop talking with all of us. We do have a duty of care to tell you if we found out about an immediate and significant risk of harm to him or someone else".

The counsellor offers services (or referral) to Sandra for support. "Sandra you are more than welcome to attend the service if you would like to find out more or for some support to help with Mark".

Source: Kelly and Francis, undated. 13.

Breaching confidentiality

According to the National Children's and Youth Law Centre (NCYLC) (2004, 35) there are five defences which may be raised by a counsellor accused of breaching their duty of confidentiality, these being:

1. The information was not obtained in confidence;
2. The client consented to disclosure;
3. Disclosure was required to inform a court of law;
4. Law required mandatory disclosure; or
5. Disclosure was made in the public interest.

The second of these defences - that the client consented to the disclosure - is clearly preferred in AOD practice, as it is less likely to undermine the therapeutic alliance or casework relationship, and reflects ethics around autonomy and respect.

The public interest defence applies only to serious circumstances where there is risk to self or others.

A serious risk must reflect significant danger, such as a life-threatening situation or one that might reasonably be expected to result in serious injury or illness to a patient, the patient's family, an employee of the department, or any other member of the community (*Health Services Act* 1991 (Qld) Part 7, 6.8: Disclosure to prevent serious risk of life, health or safety etc).

It is important to note that there is no legal obligation for an individual to inform police of a crime no matter how serious (Youth Advocacy Centre 2009).

Public interest disclosure has not been as widely interpreted in Australia as in some other places, and it has been held that the defence does not extend to disclosure of actual or threatened breaches of security of the law or misdeeds of similar gravity relating to matters such as public health. However information regarding serious crimes, such as the sexual abuse of a child, has been recognised as falling within the public interest defence in Australia.

Source: The National Children's and Youth Law Centre. 2004. Counsellors and their child clients. 38. [www.ncylc.org.au]

This duty to warn is a legal requirement for practitioners to balance confidentiality with public interest regarding threatened harm to others, or threatened harm to self. A key principle is:

The greater the likelihood of serious harm the greater the imperative to disclose.

Source: Kennedy with Richards 2007, 90.

Case law provides some guidance around the criteria which create a legal duty to warn. These are indicated by Kennedy (2009, 171) as:

- the victim is clearly identified
- the plan to kill or do serious bodily harm is specific
- the danger is imminent
- the client has the means, and steps to protect the victim are practicable

Here are two examples of where confidentiality was breached in youth AOD practice on the basis of public interest. The first relates to the real prospect of harm to others arising from being intoxicated:

Kate arrives at a counselling session clearly very drunk. She had somehow driven to the appointment and when asked, indicates that she also plans to drive home. I said to her "Kate you appear to be too intoxicated to drive today, have you got any other way to get home?" to which the client says "No". I offer to find alternative transport for her and when she flatly refuses this and goes to get in her car I inform her that I have an obligation to breach her confidentiality and notify the police as I believe that she is going to drive when intoxicated and put herself and others at imminent risk of serious harm. She tells me that she doesn't think that she is that drunk and that she just lives a couple of suburbs away… and then leaves… I call the police and she is subsequently pulled up and charged.

Frontline youth AOD worker

The following concerns a threat of violence:

I had been working with a male client in his early 20s for about 3 months for relapse prevention because he was under stress due to a recent relationship breakdown. He had already told me that he had a pretty full-on history of violence so I knew he'd had an angry streak, but since stopping his use quite some time ago he had been fairly stable. In the lead-up to Christmas he ended up in a fight with his ex-partner over access to their children over the holiday period. On one particular session he presented extremely agitated and said that he was planning to go around to his ex-partner's house on Christmas Day with a baseball bat and bash her and her new boyfriend. After attempting to discuss this, my assessment was that he intended to carry out his threat. I told him that I had an obligation to notify the police if I felt that he was actually going to go ahead with his threat, to which that he said that he was very serious about doing it. I had explained the bounds of confidentiality during our first session and so I was able to remind him of my obligations. So, after the session, I phoned the police and informed them of what my client had stated, and then phoned the client to let him know that I had just been speaking with the police. Subsequently the police rocked up on my client's door to follow-up the matter (and no such attack took place). Interestingly, I continued working with this client for some time and the breach didn't seem to damage our therapeutic relationship, which at the time I found very surprising. On reflection I think he responded to the openness and honesty.

Frontline youth AOD worker

As you can see from these two examples, there are circumstances where breaching a client's confidentiality can be quite clearly argued and/or justified. Unfortunately not all situations will be this clear, and workers may need to assess the level of risk subtly or overtly depending on the particular case, situation, level of risk and whether there is any likelihood that the client may abscond if they suspect their confidence is about to be breached.

The *Health Services Act* 1991 (Qld) Part 7 provides Confidentiality Guidelines for those deemed a 'designated person' (Queensland Health officers, employees and volunteers) or 'health professional' (a person registered under a health practitioner registration Act or person who provides a health service).

The *Health Services Act* 1991 (Qld) Section 62 requires that staff covered by the Act must gain permission in writing from the Director-General or their delegate before a disclosure is made.

In health and human services, a variety of risk assessment protocols and procedures have been developed, for example suicide risk assessment protocols.

There is also legislation to protect disclosures that are sometimes referred to as 'whistle blowing'. For more information see Queensland's *Public Interest Disclosure Act* 2010.

As a part of the Queensland Government Suicide Prevention Strategy 2003-2008, the Department of Communities published a series of guides to assist agencies in developing their own policies and procedures to assist in identifying and responding to young people at risk of suicide. These guides are available from the Department of Communities Website: www.communities.qld.gov.au

What can you and your organisation do to become better prepared to respond to people at risk of suicide?

- Develop organisational policies and protocols which clearly outline how staff and volunteers will respond to those at risk. The Department of Communities has developed some guiding principles to assist organisations to develop policies and protocols for responding to clients at risk of suicide and self-harm. This resource can be accessed through the Department of Communities website at www.communities.qld.gov.au/resources/communityservices/community/documents/principles-for-developing-protocols.pdf
- Find out what role other services in your local area play in responding to people at risk of suicide. Build working relationships with key services and develop referral protocols where appropriate. Maintain a contact database of key referral services that can be accessed by staff and volunteers in your organisation and keep a supply of brochures from relevant services that you can provide to people as needed.
- Attend training in suicide risk assessment and intervention. There is a broad range of introductory and advanced level training programs available across Queensland. As the evidence base for effective suicide prevention changes with new research, it is also important to attend refresher training to update your skills.
- Find out if there is a local suicide prevention network in your region. Think about how the network can assist you with your work and how your organisation can contribute to achieving the network's goals.

Source: Department of Communities 2008.

Responding to people at risk of suicide? How can you and your organisation help? Brisbane: Department of Communities

4.1.6 Privacy

Privacy provisions govern the collection, storage, protection, use, correction to, and disclosure of personal information. *The Privacy Amendment (Private Sector Act)* Act 2000 (Cth) broadened previous Commonwealth legislation applying to Federal Government departments (Privacy Act 1988 [Cth]).

The Commonwealth legislation specifies **10 National Privacy Principles** (NPP's) and 11 Information Privacy Principles (IPP's) respectively. NPP's apply to private organisations including practitioners and organisations offering health services or collecting information. Health and community services procedures and practices need to be consistent with these. The Commonwealth privacy requirements can be found at www.privacy.gov.au

The Commonwealth Privacy legislation does not regulate Queensland Government departments, agencies or government owned corporations. The *Information Privacy Act* 2009 (Qld) provides rules for how agencies may or must handle people's personal information. The Office of the Information Commissioner (www.oic.qld.gov.au) provides information on these requirements.

It is important for youth AOD workers to keep their client's details and records private and to implement systems that ensure their records remain safe and protected. Many government departments and community organisations have strict policies regarding the collection, storage and transportation of client files which all workers should ensure they are familiar with, as the following case example illustrates:

I've known workers who carry clients' files around in the backs of their cars and leave them there whilst they pop into the shops. What would happen if that car got stolen? Or if you've written a client letter on a personal laptop at home, which includes the client's full address details, and later you accidentally leave your laptop on the bus?

Frontline youth AOD worker

With rapid developments in the use of centralised data systems and communication technologies, and increased pressure to share information between agencies, privacy is an aspect of practice that is guaranteed to continue changing.

4.1.7 Natural justice and procedural fairness

Natural justice and procedural fairness are concerned with the way administrative decisions which directly impact on people, are made. These terms are often used interchangeably. Natural justice and procedural fairness are important principles for all decision making about young people and not just for those that are open to formal review.

Natural justice and procedural fairness require:

Open and clear processes of decision-making, which explicitly identify the evidence, the reasoning and authority used to reach a decision, and provide a clear and succinct statement that sets out these elements and can be challenged. Procedural fairness also demands that those affected by a decision have the opportunity to know the detail of the case against them, to challenge the basis of that case, to mount an alternative argument, and to know the avenues for further appeal, if any.

Source: Swain and Bigby 2009, 339.

There are a number of important principles underpinning natural justice and procedural fairness:

- **The hearing rule** means a young person has the right to know that a decision affecting them is being made and have the opportunity to put their position on it.
- **The rule against bias** means the decision maker must be impartial.
- **Conflict of interest** *exists if a decision maker has a personal interest in the outcome that might prevent them, or appear to prevent them, from performing their duty impartially'. (Australian Review Council 2007 Guide 2:1)*
- **The evidence rule** means decisions must be based on factual evidence.
- **Duty to enquire** requires the decision maker to seek relevant information, and clarify matters, so as to have a complete an understanding of the situation before making a decision. (Kennedy with Richards 2007, 40)

Youth services and practitioners (as well as courts and tribunals) need to utilise these principles in any decision making which may impact negatively on their clients.

Sasha, a 15 year old young woman, is visiting a service to see her case worker. The case worker has been informed by another client that Sasha is providing drugs to other young people during group activities. When approached about this, Sasha tells the worker to 'get lost'.

What would need to happen for Sasha to be afforded natural justice and procedural fairness in this situation?

- Sasha should be told what the concerns of the agency are, including what information / evidence they are relying on if they make a decision.
- The concerns of the agency / worker should be reasonable, lawful, and not involve a conflict of interest.
- Sasha must have the chance to put her side / challenge what has been said.
- This should be done in a way that allows Sasha sufficient time to respond fully and encourages Sasha to be able to communicate freely.
- Sasha should be told what options are being considered.
- When a decision is made, this and the reasons for it should be given to Sasha, along with what opportunities exist for her to appeal.

For more information on decision making see

Australian Review Council Best Practice Guides
www.ag.gov.au/agd/WWW/arcHome.nsf

Key points for workers to appreciate about decision making

- Decision making should be undertaken consciously and carefully even if a decision may not be subject to formal administrative review.
- What seems like a small decision to you may have substantial consequences for the person you make it about.
- It is important to weave natural justice and procedural fairness principles into your everyday practice.
- Decision making is also influenced by other contextual factors and you need to consider this complexity.
- In exercising discretion or making decisions, workers need to be acutely aware of the power of their position, and make sure those about whom decisions are made - clients, families, communities – are actively involved in the process (Swain 1995, 259).
- Natural justice and procedural fairness requirements mean that client participation can have a LEGAL basis beyond notions of good practice and ethics.
- Services and practitioners must be able to account publicly for the decisions they make about people.

Best interests

Best interests is an important guiding principle for AOD practice with young people.

In Queensland the Commission for Children and Young People and *Child Guardian Act* 2000 (Qld) (Sec 6) indicates that the:

(1) Best interests of a child are paramount.

(2) (a) every child is a valued member of society;

(b) in decisions involving a child, the child's views and wishes should be taken into account in a way that has regard to the child's age and ability to understand;

(c) every child is entitled—

(i) to be treated in a way that respects the child's dignity and privacy; and

(ii) to be cared for in a way that protects the child from harm and promotes the child's wellbeing; and

(iii) to express the child's concerns and grievances and to have them dealt with in a way that is fair and timely and promotes the child's participation; and

(iv) to receive information and help to enable the child to exercise the child's entitlements; and

(v) to have access to services necessary to meet the child's needs;

(d) the family has the primary responsibility for the upbringing and development of its children, and should be supported in that role.

Whilst the Convention on the Rights of the Child is not mentioned specifically, these provisions indicate children are themselves seen to hold human rights. The principle of best interests also underpins other legislation such as the *Child Protection Act* 1999 (Qld). The legislation and an explanation of the Act are available at www.communities.qld.gov.au

I'm working with a young woman at the moment who has a history of mental health concerns. She's had a recent admission to a mental health unit on an Involuntary Treatment Order (ITO). She was then released to the community with no mental health follow up, and then presented to our service. She presents with significant anxiety and depressive symptoms and I've booked her in to see a psychiatrist through our service. When I sent the notes through to the psychiatrist, his response was "You need to be sending her back up to mental health immediately for assessment". I went "You know what, I know I don't want to do that, I don't think she's actively suicidal, and I don't want to send her back through the adult system again because she has great difficulties navigating that, she needs support that's developmentally appropriate through a more youth focused agency".

Frontline youth AOD worker

This example highlights differing conceptualisations of 'best interests'. The organisation's psychiatrist wants to refer the young person back to the adult mental health system as, according to the case notes, he thinks this would be in the best interests of the young person. However the youth worker believes that it is in the best interest of the client to be supported through community based, more youth friendly strategies.

A word of caution. There has been quite substantial debate about the meaning and use of the best interest principle, including the view that it can be used to argue a particular position as necessary by a stakeholder or professional (Hansen and Ainsworth 2009). Given the primacy of the best interests principle it can be used as code for 'We must do it this / my way because it is in the best interests of the child.' This can have the effect of shutting down debate and dialogue, presupposing certainty when the situation may in fact be inherently messy, uncertain and complex. When contested in legal processes, it is courts that ultimately determine what is in the best interests of a young person.

When I hear someone use the term "best interest" I wonder if they are saying this just to support their own personal perspective or position, or if this is something that is really in this young person's best interests?

Frontline youth AOD worker

4.2 Legal 'potholes'

There are a number of legal 'potholes' for workers to be aware of, including:

- breach of statutory duty,
- breach of contract,
- negligence (duty of care, breach of standards, harm as a consequence),
- criminal behavior.

Law in these areas can be very complex and workers and services should seek legal advice if they have a problem or concern.

4.2.1 Breach of statutory duty

Laws can require compliance from citizens generally (e. g., the criminal code), or from particular people and agencies in particular circumstances. If a law says that we are required to perform duties in a particular way and we don't, then this can be a breach of statutory duty.

4.2.2 Breach of contract

A contract is an agreement. One person makes an offer that is accepted by the other person. A contract is made when both parties understand what they are doing (making a contract) and have the legal capacity to make a contract.

Source: Kreet and Uhr in the Queensland law handbook, 2011, 60.

It is important to remember that an oral agreement is also a binding contract unless a written contract is required by law (Kreet and Uhr 2011, 61). It is important you know that contracts of one form or another are everywhere in a practitioner's life, and becoming more utilised as health and community services are privatised and corporatised.

Many workers are now employed through specific contracts with organisations, and organisations enter into contracts every time they accept government funding or develop formal arrangements with other organisations. Contracting can also condition frontline practice through case management agreements and permission to collect data from clients.

Key points for workers to appreciate about contracting

- Be aware of the contracts that apply to your practice setting.
- Appreciate that because contracts are agreements, they can be negotiated, clarified and possibly renegotiated. They also often have time limits. Part of good practice is negotiating contracts that are in the best interests of clients, and advocating for change when this is not the case.
- Appreciate the potentially positive and limiting role contracts can play in your client's everyday life, for example tenancy contracts, financial contracts (credit cards, debts).
- Young people under 18 years have limitations in what contracts they are able to enter into. It is best to check with a relevant agency (for example, the Tenants' Union of Queensland in respect of rental accommodation and social housing) for contracting rights and limitations that might affect a young person in a particular situation.

Negligence (including duty of care)

Negligence is 'a failure in law to do what a reasonable person would have done in the circumstances to avoid loss or injury to the plaintiff' (Neil and Barrett 2011, 632).

Negligent misstatement involves giving wrong, gratuitous or 'careless' advice which results in harm to the person it is given to. Practitioners need to exercise care in what they advise people to do as wrong advice can be costly (Kennedy with Richards 2007, 140).

Establishing negligence is something only a court can do. For negligence to be established three (3) criteria have to be proved in court by the person alleging negligence:

- that they were owed a duty of care
- that the duty of care was breached
- that the breach caused them damage

Whilst physical damage (for example injury) is the most tangible for a court to assess, other forms of damage (for example psychological) can also be recognised.

A young person using your service claims that your organisation was negligent because they did not require young people to wear provided seat belts when travelling on a bus to a group activity. As a result of an accident the young person sustained physical injury which involved a week in hospital and an operation on their leg. The court could decide the service did have a duty of care given the trip was a service activity, that a reasonable standard of care would be for people on the bus to wear seat belts when available, and that damage to the young person had occurred.

A **duty of care** ordinarily commences for health professionals when the therapeutic relationship commences and professionals can owe duties to third parties who are not the client (for example partners). (Stewart, Kerridge, and Parker 2008, 34).

Health professionals owe a duty of care to those they can reasonably foresee will be injured by their actions or omissions.

Source: Stewart et al. 2008, 34.

If a duty of care is owed then a practitioner is required to exercise a 'reasonable' standard of care in the circumstances. The existence of a duty of care is the first element that must be established in a legal action for negligence. Courts then determine the standards of care that should have applied in a particular case according to what is termed the **reasonable person test.**

The standard of reasonable care and skill required is that of the ordinary skilled person exercising or professing to have that special skill (Rogers V Whitaker (1992) 175 CLR 479 at 483).

The youth worker has a duty to take precautions / actions to the standard that a reasonable youth worker would have taken.

Source: Wight and Hoyer 2009, 91.

In formulating what is a **reasonable standard of care** courts can take into account:

- the magnitude of the risk of harm;
- the degree of the probability of its occurrence;
- the expense, difficulty and inconvenience of taking action to avoid the risk; and
- any other conflicting responsibilities that the defendant has (Stewart et al. 2008, 37 citing *Wyong Shire Council v Shirt* (1980) 146CLR40)

Breaching a duty of care can involve doing something OR failing to do something. **Remember 'reasonable' does not mean perfect!**

Courts consider professional standards of care to be higher than those expected by ordinary people. Sources of what standards are reasonable in a particular practice situation can include:

- professional associations' codes and standards
- funding body requirements
- relevant research and practice literature
- professional education curriculum
- agency procedures

Civil liability legislation has been introduced across Australia to limit exposure of those delivering public services and charitable activities. This arose out of concerns that high costs of insurance would inhibit the provision of needed services. There is now civil liability legislation in each state and in Queensland this is called the *Civil Liability Act* 2003 (Qld).

***Civil Liability Act* 2003 (Qld) Section 22: Standard of care for professionals**

(1) A professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a way that (at the time the service was provided) was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice.

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational or contrary to a written law.

and also

(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

The Civil Liability Act 2003 (Qld) also gives guidance for being able to express regret about an incident without this being seen by courts as an admission of liability.

Key points for services and workers about negligence

In summary, services and workers need to consider the risk of harm to their clients from what they do or do not do, practice in ways that reflect acceptable standards (keeping in mind there are various sources of these) applied in situationally responsive ways. Organisations have important responsibilities to provide policies and procedures in areas of practice where harm may result to their staff, clients or others they may have a duty of care to. The organisation has an important role in staff development and support, and in responding to practice challenges and incidents.

4.2.5 Criminal behaviour

There are a number of areas of criminal law that are relevant to health and community services practitioners' own behaviour, including fraud, assault, and abduction / unlawful removal or keeping of a child. The last of these is briefly outlined.

As previously mentioned young people are generally regarded in the law as 'minors' until they turn 18, and their parents and legal guardians have a range of legally recognised responsibilities in respect to that child. Guardianship remains with parents until the child turns 18 unless a court order has been made which changes this (Wight and Hoyer 2009, 118).

There is no legal age for when a young person can leave home. This said, a young person capable of making their own decisions may be able to leave home before they turn 18.

If you are under 18 and the Department or the police are told / find out that you are not living at home, they will need to be convinced that you can care for your basic necessities of life. This means looking at whether you:

- *are homeless,*
- *can adequately care for your basic needs (food, shelter, clothing, medical, mental health), and have adequate supervision.*

Source: Youth Advocacy Centre. 2012."Moving out: Information sheet." www.yac.net.au]

Laws relating to abduction and unlawful removal of a child indicate 16 years as a threshold age:

Under the Criminal Code of Queensland provisions 'abduction' is outlined as:

s363A (1) Any person who unlawfully takes an unmarried child under the age of 16 years out of the custody or protection of the child's father or mother or another person having lawful care or charge of the child, and against the will of the father, mother, or other person, is guilty of a crime, and is liable for imprisonment for 7 years.

(2) It is immaterial that the offender believed the child to be of or above the age of 16 years.

(3) It is immaterial that the child was taken with the consent of or the suggestion of the child.

Source: Wight and Hoyer 2009, 118.

Under the *Child Protection Act* 1999 it is also an offence to unlawfully remove, or keep a child who has been unlawfully removed, when that child has been placed into the custody or guardianship of the Department (currently the Department of Communities, Child Safety and Disability Services).

Section 5

Organisational policies and expectations

As part of considering what to do in a particular practice situation, workers should ask "What does my organisation say?" There are various sources of guidance and requirements that come from what can be broadly described as 'policy'. Importantly frontline workers generally gain their mandate and role definitions through their employing organisation, with organisations in turn having a clear responsibility to adequately support their staff.

5.1 Agency policies / procedures and management

Organisations and services need to have a range of policies and procedures, required as part of quality assurance and funding requirements, and necessary as part of providing good management. As part of a duty of care, organisations need to ensure that their staff are given appropriate guidance in those aspects of service delivery which present foreseeable risk of harm. Services in the youth AOD field face a number of challenges where specific policies may be necessary. These include (not exhaustive):

- when to contact parents
- participating in activities, trips and camps
- weapons
- AOD use
- working with young people under 16
- responses to critical incidents
- home visits
- transporting young people
- when to contact police
- how to handle child protection concerns
- practice with young people in high risk situations

Agencies often network with other agencies that have more developed policies and procedures as a way of informing themselves. Whilst doing this is quite sensible, agencies must make sure they develop policies and procedures that fit their context and do not just ceremonially conform to their external environment. Good policies and procedures are relevant, known about, understood and living. Quality assurance processes increasingly require funded services to have a wide range of policies in place and actively used.

Further discussion about organisational policy for service delivery in a number of particularly important areas identified by youth AOD practitioners can be found later in this section of the Guide. These are:

- working with young people under 16
- practice with young people in high risk situations
- dealing with child protection concerns

5.2 Standards

There are various Standards that may apply to a particular practice context. Some Standards are aspirational and 'best practice' oriented, some are available for accreditation, and others form part of the regulatory environment a practitioner works in. Standards developed to apply to particular services and areas of practice are not the same as the reasonable 'standard' of care that a court may determine should have been used in a specific situation (e. g., for establishing negligence) but can used as one source taken into account.

Governments have moved in the past decade to introduce Standards as means of assuring quality in health and community services.

Table 4: Standards in health and community services

STANDARDS	FOCUS	FOR INFORMATION
Australian Council of Healthcare Standards	Offers accreditation services, standards development, clinical indicators and education services. The Evaluation and Quality Improvement Program (EQuIP) is the core accreditation program.	www.achs.org.au
National Safety and Quality Health Service Standards	Focus on improving patient safety and quality of care and include: • Governance for Safety and Quality in Health Service Organisations • Partnering with Consumers • Preventing and Controlling Healthcare Associated Infections • Medication Safety • Patient Identification and Procedure Matching • Clinical Handover • Blood and Blood Products • Preventing and Managing Pressure Injuries • Recognising and Responding to Clinical Deterioration in Acute Health Care • Preventing Falls and Harm from Falls	www.safetyandquality.gov.au
The Health and Community Services Standards (6th edition) **Published by Quality Improvement Council Limited (QIC)**	A set of 18 standards including: • governance and management, • building quality services, • providing quality services and programs, and • managing the external environment.	www.qic.org.au
Queensland Health 'Standard' statements	A range of implementation standards regulating health care provision in Queensland, including an Informed Decision-making in Healthcare Implementation Standard.	www.health.qld.gov.au
Standards for Community Services	Outlines the minimum expectations of NGOs providing services recurrently funded by the Queensland Department of Communities.	www.communities.qld.gov.au

Various professions (for example social work, psychology, and nursing) have Standards which apply to those who meet their accreditation and/or registration requirements. Various other Standards may apply to specific aspects of service delivery, examples being:

- occupational health and safety standards
- food standards

5.3 Consumer / client rights statements and policies

Patient and consumer rights are a critical consideration in any health care setting and are differently specified across various health care contexts. In 2008 the **Australian Charter of Healthcare Rights** was endorsed with the following rights specified:

Access: You have a right to health care

Safety: You have a right to safe and high quality care

Respect: You have a right to respect, dignity and consideration

Communication: You have a right to be informed about services, treatment, options and costs in a clear and open way

Participation: You have a right to be included in decisions and choices about your care

Privacy: You have a right to privacy and confidentiality of your personal information

Source: Australian Commission on Safety and Quality in Health Care. 2008. Australian charter of health rights. [www.safetyandquality.gov.au]

The **Queensland Health Quality Complaints Commission** (QHQCC) monitors and reports on healthcare quality and manages healthcare complaints. The QHQCC website is www.hqcc.qld.gov.au

At the service level **consumer or client rights and responsibility policies** are particularly important and seek to provide protection for people who are consumers of services.

It is important that these policies are explicit and available, give clear emphasis to rights and not just constraints (responsibilities), and are in an accessible and meaningful form.

Clients may have rights to access information held about them under a range of legal and policy provisions including the *Right to Information Act* 2009 (Qld).

Be aware that it is often easiest for services and workers to respect those consumer and client rights that fit with their particular model of service and more challenging to respect other rights which may not fit so neatly.

Does your service have a statement of rights and responsibilities that is given to young people when they first engage? How are young people supported to realise these?

5.4 Working across organisations

There are many instances where working across services, organisations and sectors brings real benefits to young people. The importance of collaboration across such boundaries to produce 'wrap around' support and 'joined up' responses is overwhelmingly accepted as essential. Unfortunately, sometimes the approaches taken by different agencies and practitioners can work against each other. The following example exemplifies how another agency, the police, worked in a highly complementary way and how this contributed to good outcomes for a young person.

We had a young person who presented to the service who was actively psychotic and quite a risk to himself, but also to staff members. When we contacted the police, they were really good, they sent officers who weren't in uniform, they were very gentle with the young person, they spoke to the young person, and it wasn't punitive. They asked for quite a lot of information from us, and were very supportive in helping the young person rather than being punitive and locking them up in the car. This meant the young person was taken to hospital and got the support that was needed at that time. It's good to build important relations with the police in your local area.

Frontline youth AOD worker

Sometimes tensions arising around differing roles and approaches to confidentiality can be transcended by creative practice. The following quote is from a youth AOD worker who suggested a collective case review of all their clients referred to him as a way of overcoming the ethical and therapeutic relationship threatening difficulty of breaching confidentiality. The result has been a range of positive strategies to improve service delivery.

The youth justice workers are often referring young people and they've got an expectation of "Well what are you doing with them?" These workers have a relationship with the client, albeit a tense one, because those young people don't want to be there, because they're telling them what they must do. And so when they come along and have a more therapeutic relationship with us, where they're getting on with us, then there's potential for some tensions with Youth Justice.

My solution is being professional, rather than just going "Oh, it's their problem" and shrugging my shoulders. I'd much rather deal with it by saying; "Well look, why don't we meet and have something like a case review of all the clients you've got referred to me. Although I can't talk to you about individual cases we can talk about what your expectations are, ways that we can work together". And it worked. I think it really did solve the problem.

We've got a really good relationship with Youth Justice particularly, and we've been working together on a lot of programs recently. An example of working well together is that they've identified that they have got a lot of young people who are injecting drugs, and so they've called us in as consultants as in "Can we respond to this differently?" And together what we've done is we've delivered a kind of training program to their cohorts, we've linked Youth Justice to specialist training around injecting drug use. So we have been able to move past the tension.

Frontline youth AOD practitioner

Whilst this is an example of a good relationship, there are other times for youth AOD workers when the interface with external agencies and practitioners can be experienced as problematic and difficult to resolve.

Organisational policy for engaging in service delivery with young people under 16

Organisations need clear policies and processes for assessing the situation of young people under 16 years of age who present for a service. The type of service being provided is an important consideration here. Providing accommodation to a young person under 16, providing a generally accessible youth drop in space, and providing clinical AOD treatment services, each bring their own suite of considerations and duties in respect of these young people.

The policy position taken by a particular service will inevitably be a mixture of legal requirements (law), an assessment of what is appropriate for that service (policy), and what is considered good practice in that type of service (practice processes and principles).

Every service should develop policies that provide guidance to staff around:

- the types and levels of risk/s to the young person that can be reasonably foreseen (level of risk and immediacy of risk)
- what circumstances a worker should inform a parent / legal guardian or child protection authorities
- assessing the capacity of a young person to give informed consent and indicate wishes (Gillick competency)
- the duty to maintain confidentiality unless there are valid grounds for doing otherwise. Where confidentiality is breached, involving and informing the young people should be emphasised and encouraged where appropriate
- the capacity of the agency to provide a reasonable standard of care and what this standard of care is, in particular circumstances. (This should include the responsibility to continue work with a young person even where a report to authorities has been made)
- recognition of the benefit of young people having ongoing support and connection with family and significant others, unless there are risks associated with this
- the legal requirement for young people to undertake approved education or training

Whilst the following paper by the Queensland Government's Department of Communities Housing and Homelessness Services (2011) refers to specialist homelessness services specifically, its principles regarding duty of care have broader application to other services for young people.

Supporting young people under 16 years of age: Guidelines for good practice for specialist homelessness services (SHS)

SHS funded services have a duty of care to all clients of the service, as well as other workers and those who are likely to suffer foreseeable harm. Services are required to take all reasonable care in carrying out their work to make sure that appropriate standards of care are met. The appropriate standard of care is assessed on what action a reasonable person would take in a particular situation. On rare occasions a client's right to confidentiality may need to be breached by a SHS if duties of care issues arise.

SHS funded services should have policies which generally ensure that procedures for reasonable actions to meet duty of care responsibilities are in place. Any action taken under a worker's duty of care obligation should be documented.

In order to meet duty of care responsibilities for young people, SHS services should consider:

- whether the service's model of operation can support young people who are under the age of 16 years;
- the need to access an interpreter or other support services for young people from culturally and linguistically diverse backgrounds;
- the need to respect and be sensitive to the cultural preferences and customs of young people from Aboriginal and Torres Strait Islander backgrounds;
- the need to respect and be sensitive to the needs of young people with a disability and aware of appropriate support services to assist young people meet their specific needs;
- how the service can responsibly meet the needs of a young person (e. g., help them develop skills to live in independent accommodation);
- how the service can work co-operatively with other services to meet the needs of the young person;
- referral to other support services when a SHS cannot responsibly provide assistance to a young person;
- the need to assist young people exiting a SHS to link with transitional or long term support services.

SHS providers must carefully consider the needs of young people under 16 years old to determine whether the service model is appropriate to meet these needs. It is also important to recognise that a SHS service may be the only service available in an emergency situation.

SHS funded providers should advise young people under the age of 16 years of their duty of care responsibilities, including the service's policies about:

- the support the service is able to provide young people under the age of 16 years,
- the circumstances in which parents of a young person may be advised of the young person's whereabouts and safety,
- the circumstances in which Child Safety may be contacted.

This information will be provided upon initial contact so that young people can make an informed decision about whether or not to access the service.

Source: Queensland Government. 2011. Supporting young people under 16 years of age: Guidelines for good practice for specialist homelessness services. [www.communities.qld.gov.au]

5.5 Organisational policy for practice with young people in high risk situations

For many practitioners and agencies involved in youth AOD work, dealing with high-risk situations is their principal concern. As has been emphasised elsewhere in this Guide, there is no simple set of responses that can be given. A wide range of considerations need to be taken into account to determine what would be appropriate in a particular circumstance. The following extract, taken from the Child Safety Services' practice paper titled 'A framework for practice with 'high-risk' young people (12-17 years)', summarises a number of key principles for this work. (Note: we have highlighted terms in the extract below).

Key principles for practice with 'high-risk' young people

When young people behave in ways that are acutely dangerous for themselves and/or others, it is necessary to **work proactively to minimise harm** until they can be helped to make changes. To do this:

Keep open and timely lines of communication with all concerned. Discuss your concerns with the young person, their family and other helping professionals. Put in place a mechanism for quick communication which keeps everyone with a 'need to know' informed (for example, an email group or phone web).

Negotiate plans for timely responses by members of the young person's care team, as relevant to their roles, with contingency plans for possible scenarios. Ensure that each member of the care team is clear about their role, and knows to keep the department and each other informed of any new information suggesting heightened risk.

Discuss 'bottom lines' with the young person, that is, any activity on their part which will trigger a non-negotiable response, possibly involving medical professionals or police. Never deliberately leave the young person uninformed about crisis-response plans, unless it has clearly been assessed as unsafe to tell them.

For Aboriginal and Torres Strait Islander young people, **consult with the recognised entity or appropriate community member** who is part of the care team. There may be current cultural or community impacts on the young person that you need to be aware of.

Organise some capacity for **flexible responses** – for example, availability of key persons out of hours, pre-approved 'standby' resources, emergency respite and out-of-hours contact numbers.

Use persistence in 'tracking' the young person, and consistency in the messages conveyed to them about the tenacity of team members in caring about them and wanting to work with them.

Learn about sound practice in responding to a young person's very high-risk behaviour, such as responding to suicide ideation, or to a growing dependency on a particular substance.

Build a working consulting relationship with specialists about these issues, and liaise with them regularly. Consult with the senior practitioner and Child Safety Service Centre (CSSC) manager, rather than acting alone.

This type of **coordinated approach to risk management and harm minimisation** requires that a care team is in place prior to any acute episode of dangerous or highly risky behaviour such as attempted suicide, drug overdose or serious assault.

Source: Queensland Government, Department of Communities. 2008. A framework for practice with 'high-risk' young people (12-17 years). 9.

Here are some specific strategies for managing risks generated from the consultations undertaken to develop these Guides. (not meant to be comprehensive)

Know what your services policies and procedures are. Discuss these with your supervisor and colleagues, especially the more experienced and well regarded ones
If policies and procedures don't exist, ask how particular situations you can foresee might happen are best dealt with
Being honest and open with young people and others about what you can and can't do to assist them
Being honest and open with young people about what you are concerned about and clarifying / discussing / contracting in a way that reduces the possibility of harm
When you are in doubt about what to do, consult your supervisor or an appropriate colleague
Document in case notes any assessments of risk you undertake, strategies to address risks and reasons for particular practice strategies and decisions (for both what's done and what's not done - commissions and omissions)
Utilise an explicit decision making process for high risk circumstances
Develop and maintain good professional networks
Engage in ongoing professional development

The following checklist arises out of the implications of previous sections in this Guide.

A checklist of questions when there is a risk of harm

Are there foreseeable risks of harm in this situation arising from what I do or do not do?

What are these risks of harm?

How significant are the risks (in both seriousness and in probability of occurring)?

What standards of care are relevant to how I respond? (legal, professional, ethical and organisational requirements, policies and standards)

What action (including precautions) should I take given the probability of harm occurring and the level of seriousness of the harm?

How will this be communicated and documented?

When will I revisit these questions and how will I maintain currency?

Perhaps the most effective thing practitioners and services can do to manage risk is to **proactively, reflectively and continuously** appreciate the potential risks for harm in particular service contexts and seek to minimise these. The ethical principle this is based on is 'non-malfeasance' which requires the active avoidance of harm to others (individual and social) (Fry 2007). In the context of other requirements this involves minimising risks of harm to clients, the service and others, whilst still engaging purposefully in outcomes oriented ethical practice.

Managing risk is everyone's responsibility. It should not just be left to practitioners to grapple with the often embedded tensions and mixed messages of 'pointy-end' youth AOD practice. Policy and law makers, education and training providers, agencies, managers and supervisors all have important roles in establishing arrangements for frontline practice that are sufficiently coherent.

Unfortunately there is no way of entirely removing risk from practice around problematic AOD use by young people. Considerations of risk should not result in simply becoming **risk averse** as a matter of habit, or in simply **downloading risks** to the less powerful (most commonly the client but sometimes the individual practitioner). Appreciate that there are many pressures in the broader environment to **individualise risk** (see pages 16-17 in Guide 1 outlining 'A Framework for youth AOD practice').

The Queensland Government Department of Communities in the **Standards for Community Services** - under Standard 6 titled 'Protecting safety and wellbeing' - requires organisations to provide services in a manner that protects the safety and wellbeing of the people who use them. This requirement comprises strategies for both **harm prevention and harm response** (Department's language). The full set of standards can be downloaded from www.communities.qld.gov.au

Standard 6: 'Protecting safety and wellbeing'

Harm prevention: The organisation develops, implements and reviews policies and procedures for minimising the risk of harm to clients

Elements to consider about harm prevention include:

- how risk of harm is assessed, taking into account risks from:
  - other clients
  - actions (or inaction) of staff in the organisation
  - physical surrounds
  - the nature of the service
  - the client themselves, to themselves and to other clients, and to people beyond the organisation
- the process to inform clients about how their safety and wellbeing will be protected, and any actions they are required to take or not take while using the service
- strategies in place to minimise and promptly respond to aggressive behaviour or physical threat
- other strategies to respond to risk such as:
  - prominent listing of emergency numbers
  - the availability of first aid kits and staff trained in first aid
  - procedures for maintaining good hygiene and dealing with infectious illnesses
  - safe environments for children

Harm response: The organisation develops, implements and reviews policies and procedures for responding to potential or actual harm that may occur for clients

Elements to consider about harm response include:

- the process for identifying, recording and responding to allegations of harm to people arising out of services received, and if appropriate, for reporting the allegations to relevant agencies including the Department of Communities
- strategies for ensuring that responses take account of the principles of natural justice and that all parties are supported during the investigation
- the agency's response to disclosures of harm, or potential harm, where the harm does not arise out of services received

Source: Queensland Government. 2007. Standards for Community Services, 14. [www.communities.qld.gov.au]

In providing advice to staff some agencies have developed a **specific policy which identifies the processes the agency and workers will use to meet its duty of care obligations where there is a risk of harm.** This is in addition to specific policies for different aspects of practice such as the transportation of young people.

Table 5: Some strategies for managing ethical and legal risk at the service level (not meant to be comprehensive)

Develop and systematically review policies and procedures in areas of foreseeable risk to service users and staff
Ensure endorsed policies and procedures reflect accepted good practice and that staff are supported to understand and maintain a currency in these
Create a service culture where staff are comfortable and have the opportunity to raise their practice worries and issues
Clear and regular supervision
Embedded process for critical incident debriefing articulated to policy and procedures review
Use a proactive inquiry process in respect of emerging practice challenges and risks, e.g., a new pattern of AOD use amongst young people using the service
Maintain a risk management policy that is developed through input from various sources including staff and clients
Develop and maintain good sector networks
Develop and maintain links with specialist agencies including relevant legal services

Remember there is no replacement for reflective practice!

5.6 Dealing with child protection concerns

In the course of professional duties workers may be confronted by an awareness or reasonable suspicion that a child, especially those under the age of 16 years, is experiencing (or is at risk of experiencing) harm or neglect. In such situations the worker's ability and confidence to respond in the best interests of the child is enhanced if they know what is expected of them legally and organisationally.

The *Child Protection Act* 1999, s.9 defines 'harm' as any detrimental effect of a significant nature on a young person's physical, psychological or emotional wellbeing. Harm may include neglect, physical harm, emotional harm and sexual abuse. It is immaterial how the harm is caused.

Specifically, workers should be aware of:

- the threshold that triggers statutory involvement;
- legal provisions required by specified roles to report child protection concerns or suspicions;
- their own agency's child protection policies and procedures; and
- ethical considerations as to how to respond at the interface between autonomy and risk.

Mandatory reporting is the legal requirement for specified people to report suspected cases of child abuse and neglect. The *Child Protection Act* 1999 (Qld) identifies discrete categories of professionals working in particular contexts as being mandated notifiers under legislation. At the time of writing these are:

- **An authorised officer, employee of the Department** [responsible for Child Safety] or a **person employed in a departmental care service** is required to report harm or suspected harm to a child in the care of a departmental care service or a licensee (*Child Protection Act* 1999, section 148).
- **Staff of the Commission for Children and Young People and Child Guardian** are required to report a child who has suffered or is at risk of suffering harm and does not have a parent able and willing to protect them (Commission for Children and Young People and *Child Guardian Act* 2000, section 20).
- A **doctor** or **registered nurse** who is aware (or has reasonable suspicion) during the course of their duties that a child either has been or is at risk of harm (*Public Health Act* 2005, section 191 and 192). [www.health.qld.gov.au/Publichealthact].
- **Family court personnel and counsellors** (*Family Law Act* 1975, section 67ZA)
- **School staff** are mandated to report sexual abuse by a school employee under the *Education (General Provisions) Act* 1989.

In Queensland only these categories of professionals are required **by law** to report suspicions of abuse or neglect that they form in the course of their work. If a worker's professional context is not identified as having mandated responsibilities then there is no legal requirement to report suspicions.

Although a worker may not have a legal requirement to notify, they may have an organisational policy or professional obligation, or feel they have a moral obligation, that may affect their decision whether to make a notification or not.

In this case the worker needs to refer to their own agency's policy and procedures to determine what position the organisation has. An organisation's child protection policy, procedures and program guidelines hopefully provide workers with context and a framework for understanding what is expected of their role, their responsibilities and duty of care when responding to children and young people at risk of harm.

An example is **Queensland Health's Child Safety-Health Professionals Capability Requirement and Reporting Responsibilities** policy and procedures. The stated intent of the policy is to ensure all health professionals are aware of their roles and responsibilities in recognising, reporting and responding to children and young people who have been harmed or are at risk of harm. The policy states clearly the legal responsibility of those Queensland Health staff whose professional context means they are mandatory notifiers. In addition, Queensland Health's organisational position (stated through its policy) is that it is expected that all Queensland Health Staff will be required to report suspicion of harm:

This policy requires all health professionals, who in the course of their normal duties formulate a reasonable suspicion that a child or young person has been abused or neglected in their home/community environment, is to immediately report their suspicion to the Department of Child Safety. This reflects the requirement of Section 22 of the Child Protection Action 1999 and also the duty of care principle.

Source: Queensland Health. 2008. Child safety-health professionals capability requirement and reporting responsibilities policy and procedures.[www.health.qld.gov.au]

All Queensland Health workers are responsible for implementing the policy. To assist the worker, the policy's corresponding procedures outline the way (process) the notification will be made, and directs workers to the necessary forms, processes and support documentation.

A similar procedure is provided by Education Queensland to guide people working in the education context. The Education Queensland '*Information Sharing Under Child Protection Act* 1999' procedure can be accessed at www.education.qld.edu.au

It is important to note **the diversity of the broader youth AOD sector and how this will impact on an organisation's or an individual worker's response to issues of child safety**. Organisations differ in terms of their size, mandate, their location within the service system, funding arrangements, client group, mission and values, staff and resources. Each organisation should have its own advice to workers on why and how to respond in harmful situations. Policies and procedures differ across organisations. No matter what size the organisation, its location in the child / youth service system or funding arrangements, it is important that clear child protection policy and procedures are developed and understood by all levels of the organisation.

For example a community based youth organisation's policy may identify that the young person's best interest is central to its child protection response, acknowledging that in some situations it may not be in the best interest of the child to report the situation to Child Safety. The following case study illustrates this:

A youth worker starts working with a 14 year old young woman and her 13 year old brother. Since their mother was admitted to hospital they have been couch surfing and are now living at their mum's ex-husband's place (not their biological father). The man and his male friends are well known to the agency for providing "a roof over the head" for kids who need some help, but the man is also well known to the police for his violence and is suspected of criminal activities involving drugs. There is concern but no evidence that he uses kids in drug deals. There is also no evidence that he treats them badly. The young person is clear that she is happy where she is at the moment and that she would run away from anywhere else; and besides the youth worker can't find alternative accommodation until at least next week. The youth worker is concerned for the welfare of these young people and she wants to take them somewhere else. She is unsure how to proceed. The agency's child protection policy and procedures guide the worker to talk to her manager. Together they explore the situation and determine that although the situation is not ideal it is not, at this point, in the children's best interest to make a formal report to Child Safety. The youth worker, in consultation with her manager, proposes that resources be allocated to actively support the young woman and her brother and minimise harm to self and others.

Frontline youth worker

There may be **broader practice considerations** than simply whether to "report or not to report". If there is not a mandatory reporting requirement then practitioners are able to utilise good case work, organisational and risk assessment processes to determine what they will do in a particular circumstance of concern. If they assess a young person as Gillick competent, then the young person should be fully involved in exploring their best options.

Child protection professional education resources and **links to key child protection agencies** can be found in 'Drilling Down 6' at the end of this Guide.

Section 6

Considering ethics and what constitutes 'good' youth AOD practice

Working with young people around AOD use brings with it a wide range of ethical and practice considerations and challenges. The effect of this is the need for practitioners to consider deeply and critically the appropriateness of their frameworks and preferred strategies for practice generally, and in any specific situation.

Some of the key ethical dimensions of practice include:

- the interface between law, ethics and organisational location in practice
- bounded professional relationships and mandate
- key ethical approaches, theories, principles and processes
- common ethical challenges and dilemmas

6.1 The interface between law, ethics and organisational location in practice

There is no rule book for ethical practice, though there are various sources of guidance. In the "real-world swamp of practice" (Bowles et al. 2006, 42) it is often not possible to know with certainty what is best or optimal to do - the contexts of practice are too complex and multi-dimensional for this. Therefore we strive to achieve the best that can be achieved in the circumstances. This requires the ethical skill of **situational awareness**, the capacity to **identify and gather relevant information** (legal, organisational, social, cultural information etc.), **organisational competence** (understanding your workplace and what informs policy and procedures), and the **ability to think and act strategically.**

6.2 Key ethical approaches

Some of the tensions practitioners experience arises from the presence of competing ethical values and principles.

Ethics involves the systematising, defending and recommending of concepts of right and wrong behaviour. It is usually divided into three areas: meta-ethics, normative ethics and applied ethics. 'Meta-ethics' involves consideration of the origins and meaning of ethical principles including their possible social construction or derivation from individual emotions. 'Normative ethics' attempts to identify moral standards that regulate right and wrong conduct, including good habits that should be acquired, duties that should be followed or the consequences of our behaviour on ourselves and others. 'Applied ethics' is the consideration of specific controversial issues using the conceptual tools of meta-ethics and normative ethics to try to resolve these issues. Normative ethics has been particularly important in the evolution of drug policy.

Source: Wodak 2007, 59.

The ethics for practice with young people is a form of applied ethics. What are the main ethical perspectives relevant to AOD practice with young people?

Deontological (Principle based)

Deontology considers what is right is determined by duty, rights, or obligation and assumes that human beings are rational and that moral rules are universal and will apply across all cultures and times (for example 'do not lie', 'do not kill'). … Deontologists might argue that a youth worker confronted with an at-risk runaway teenager should always immediately inform the parents as they have the right to know if their child is in danger.

Source: Chenoweth and McAuliffe 2012, 63-64.

Similarly a deontological approach would underpin the opposing view that the rights of the child to be heard should always be respected in any decision making process. Moral rules arising from duties, obligations and rights are seen as universal and reciprocal, and apply across cultures. Moral principles such as abstinence, treating all people with respect, universal human rights and obligations to maintain 'confidentiality' are examples.

Consequentialist (Outcomes based)

From a consequentialist ethical perspective, good decisions are made by weighing up alternatives according to whether they would result in benefit, or 'more harm than good'. That is, by prioritising possible consequences.

In a consequentialist approach, the outcomes of a particular action or decision are regarded as the basis for proper moral assessment of that action. Thus, according to a consequentialist framework, morally right actions are those whereby an action produces predominantly beneficial consequences. A concern often expressed about consequentialism is that it appears to justify an 'ends justifies the means' approach.

Source: Wodak 2007, 59.

Using the example above about the 'runaway' teenager, a consequentialist approach would underpin the view that it is essential to consider the consequences (intended and unintended) of immediately informing the parents. The concept of harm reduction reflects a consequentialist approach to ethics.

Virtue-based

Virtue ethics focuses on the character of the person doing the acting and the values and principles that underpin being of good character. Virtues are specific positive character traits such as courage, prudence and practical wisdom (Bowles et al. 2006, 56).

A virtue approach to professional ethics has become more evident in recent years with virtues such as 'integrity' and 'diligence' underpinning contemporary professional codes of ethics. What would a caring and compassionate worker do in respect of the 'runaway teenager'? What response would demonstrate integrity?

Relational

What is right from relational perspective is what appreciates and builds relationship. Gilligan (1982) contrasts the 'ethic of care', which focuses on relationships and responsibilities, with the 'ethic of justice' which focuses on individualised rights and duties (Banks 2010, 16). A relational approach has been suggested as better fitting with the way women understand what is 'right', as well as better appreciating cultural connection. In youth AOD practice, building the young person's connection and relationship to the people and structures that can support and sustain them is an important goal of practice.

Using the example above about the 'runaway' teenager the worker could consider what relationships are most important to the young person (or missing), and how these relationships can be supported and developed in equitable ways. An ethic of care would also inform the case work relationship.

Proactively building the relational support around young people is a key component of ethical practice. What's 'right' is what builds relationships.

Ethical approaches in the AOD field

Analysis of these ethical approaches recognises that different ethical perspectives have underpinned AOD policy over time (Wodak 2007). Since the late 1980s research evidence has clearly endorsed a harm reduction approach in Australia, which is reflected in AOD practice policies and frameworks. **The shift has been from use of deontological ethical thinking** and normative ethics (morality, abstinence, principles for right behaviour) **to consequentialist ethical thinking** (harm reduction).

Whilst the efficacy of the shift to harm reduction has been overwhelmingly supported by evidence, the 'war on drugs' discourse, categorisation of much drug use as illicit, and continued fear in the sections of community about any form of AOD use by young

people, has sustained the need for practitioners to repeatedly justify their practice on deontological grounds.

Emotive media reports of young people using AOD can often serve to reinforce this deontological paradigm – look at some of the media reports that emerge during Schoolies week as an example.

The goal of harm reduction places the primary focus on the outcomes of intervention rather than simple adherence to deontological principles. The use of assertive outreach to engage a hard to reach target group is a case in point. From this consequentialist perspective practice processes and virtues are enabling the outcome of harm reduction, rather than self evident. This might also help explain why managing risk (unwanted outcomes from intervention) has become a key focus in youth AOD policy and practice.

At the same time the helping professions hold as central a range of principles and values which reflect deontological and virtues thinking. Commitments to good process, respectful engagement, and confidentiality reflect deontological thinking, whilst integrity, trustworthiness and honesty reflect important virtues. Further practice is often oriented to improving relationships between people and others significant to them, and with social institutions. Social and ecological approaches to case work are underpinned by relational thinking.

Statements and guidelines for ethical practice and specifically ethical youth AOD practice contain values, and principles and ideas drawn from all of these approaches. Many of the most challenging situations in youth AOD practice involve tensions between the mix of various ethical perspectives, principles and expectations that services and practitioners have to deal with.

A question for workers to consider is what ethical approaches they have a preference for in particular practice situations and whether other ethical approaches may also be relevant.

6.3 Ethical values and principles

At the heart of professional practice is a commitment to service within a particular area of practice. This theme of service means the organisation and worker are there to service the interests of others, not serve their own interests.

The practice relationship is not a commercial or contractual one, though contracts may sometimes be used within them (Sercombe 2012, 83 citing May 1975).

The National Health and Medical Research Council (NHMRC) (2011, 35) Guidelines for volatile substance use (VSU) cite the following principles for ethical practice.

- respect and dignity
- best interests
- autonomy
- equity
- professionalism

These core principles are relevant across all AOD related practice with young people. The Australian Medical Association (AMA) Position Statement on the Health of Young People (1998) indicates that:

> *Where possible and developmentally appropriate, doctors should afford young people the same respect, rights and responsibilities as older patients. If a young person is able to make autonomous decisions regarding medical treatment, and wishes that treatment to remain confidential, then their doctor must respect and maintain that confidentiality.*
>
> Source: Youth Advocacy Centre, "Moving out: Information sheet." 2012. [www.yac.net.au]

As indicated earlier this fundamental respect for young people has broader application to other practitioners and practice settings.

The Alcohol and Other Drugs Council of Australia (Fry 2007) *Making values and ethics explicit: a new code for the Australian alcohol and other drug field* has identified the following core issues and values that are relevant to AOD practice. These draw on a mix of the ethical approaches referred to previously.

Table 6: Core values that underping AOD practice

CORE VALUE	PRACTICE
Access	ready access to services needed
Autonomy	enhance freedom of personal destiny (individual and relational)
Beneficence	help others
Compassion	embracing the common humanity
Competence	be knowledgeable and skilled
Community	encompassing collaboration, democratic participation, equity of access, diversity
Conscientious refusal	disobey illegal or unethical directives
Diligence	work hard
Discretion	respect confidentiality and privacy
Equity	equal treatment for equal needs
Fidelity	don't break promises
Gratitude	pass good along to others
Health	all people have a right to resources necessary for health
Honesty	tell the truth
Loyalty	don't abandon
Justice	be fair, distribute by merit
Non-malfeasance	actively avoid harm to others (individual and social)
Reciprocity	in-kind positive response towards the actions of others
Respect	prejudice free consideration of the rights, values and beliefs of all people
Restitution	make amends to persons injured
Self improvement	be the best you can be
Self interest	protect yourself
Stewardship	use resources judiciously
Transparency	openness in relation to the decisions affecting others and any limitations on such decisions.

Source: Fry, 2007, 7.

Using the list above as a prompt, try the following values exploration exercise:

WHICH OF THE ABOVE VALUES ARE MOST IMPORTANT TO …	INSERT VALUES	WHY?	EXAMPLE
You as a practitioner with young people?			
The young people you work with?			
Your team?			
Your agency?			
The funding program?			
Which of these are least important to you?			

6.4 Professional boundaries

In youth work an informal practice environment and 'youth friendly' character of communication can make it difficult for workers to specify boundaries and for young people to recognise them (Sercome 2010). Some key concepts are:

Dual relationships: Exist when, as well as the professional relationship, there is also some other form of relationship which has different obligations. This may be a personal friendship, a business or buying / selling link, an associational link (as in membership of the same community, sporting team or church), or communication outside of the professional context e. g., via social media. Whilst dual relationships should be avoided where possible in some circumstances this is not possible and they need to be managed. For example a youth worker in a small or remote community may not be able to entirely avoid social links with a client, meaning sometimes dual relationships need to be recognised, distinguished and managed.

Role approximation: When people are in a new relationship e. g., a young person having contact with a youth worker, they often 'approximate' this new relationship to an existing template drawn on past experiences (Sercombe 2012). The youth work emphasis on equality and respect can mean young people approximate the respect shown and communicativeness of a youth worker to being 'a friend' (Sercombe 2012, 79). How to understand and negotiate the meaning and boundaries of the worker- young person working relationship is a critical ethical consideration in practice.

Conflicts of interest: Concerns the boundaries between a worker's professional responsibilities and their own interests. Workers need to undertake practice in a way that their actions and decisions could not be seen by a reasonable and independent person to be influenced by their own interests. Conflicts of interest can very easily arise where there are dual relationships.

Boundary violations: Occur when a worker oversteps their organisational, casework or therapeutic relationship e. g., by engaging in an intimate friendship. Once this has occurred and the worker becomes involved in a dual relationship there is the strong risk that the client's rights may be neglected or violated. Having a clear understanding of the professional role and its boundaries is important for all workers, particularly for those who may have had their own significant personal history of alcohol and drug use.

Understandably, professional boundary violations can be difficult to identify because often the worker may be oblivious to the fact that the relationship has become blurred, or that a dual relationship has developed. Instead a worker may believe that he or she has developed a strong therapeutic alliance or positive casework relationship with a client, whereas in reality their interactions and behaviours more closely resemble a private personal friendship, or special mateship.

It is vitally important for the worker to be explicitly aware of their actions and interventions, especially during the relationship building phase, ensuring that everything he or she does is purposeful, intentional, appropriate and will not be perceived by the client as being more than a professional 'helping' relationship, therapy or treatment.

Here are some direct examples from the field of potential boundary violations and how some workers have responded to them:

I used to work in a Needle and Syringe Program and see 40 or 50 people a day. One day , when it was really busy - there was a queue - I looked up and the next client in the line was a childhood friend. We grew up in the same street, but lost touch in high school, but our mothers were still friends and stayed in regular contact. When he saw that it was me behind the counter, I could see him panic. I was straight up with him and said "Hey man, long time no see! Just so you know, this is a confidential service, so I'm not going home to tell my mum who came through today. If you want, I can get someone else to serve you if you'd like." He relaxed after that and said "'Thanks that would be good", and then asked me how I'd been going.

I had a client who was just someone I got on really well with. The working relationship was really good and I started to really look forward to our next session. My own life was pretty tough at the time and my work with this client was a really pleasant space. My alarm bells started ringing so I raised it in my professional supervision. If I hadn't done this, the situation could have entered dangerous territory.

Once I was at a big concert at the local pub and one of my clients rocked up with some mates for a drink as well. We've spotted each other and had a brief chat, and then I've wished them well and politely excused myself back to my friends. But then I've been in a conflicted situation. My friends asked me who the young person was, but I want to preserve their confidentiality so I'm cagey about the answer, which makes them suspicious. Do I just stay and keep drinking with my mates? Or do I have to ease off and have a quiet night because I don't want to be seen to be drinking too much in front of the client? Or do I ask that we move somewhere else?

So the key questions for all workers are:

What is the purpose of this working relationship?

How will this young person see or perceive my statements, actions, behaviour or responses, and could they be misinterpreted?

Sometimes a worker may be very clear about their own professional boundaries by never encouraging any 'friendship-like' behaviour, yet their client may still begin to perceive the relationship as being something more special. If a worker begins to sense or notice this with a client, it is important that they address it quickly. Suspecting that a client may be beginning to perceive the helping relationship differently - and not responding to it – could also be considered an example of having unclear professional boundaries.

The difficulty is that this blurring of boundaries rarely happens in a discrete and easily-identifiable manner. Most often it is a slow, incremental process of becoming over-familiar with a client. This is more likely to happen for workers within a long-term casework relationship model. Whilst no one single action or behaviour may have 'tipped' the relationship over the line, one day a worker may wake up and suddenly realise that the whole tone and style of relationship has changed. As described by one frontline youth AOD worker, a manager should be able to "come in and press pause" at any point in a client-worker interaction and the worker should be able to explain exactly what they are doing and why within the context of the client's caseplan and goals.

Signs or behaviours that may suggest (or confirm) that professional boundaries with a client have been blurred include:

- thinking about a client excessively or out-of-context of the professional relationship
- developing strong feelings for a client
- spending more time or acting differently with a particular client
- having very personal conversations with a client
- receiving gifts
- doing things for a client rather than enabling the client to do it for him/herself
- beginning to over-disclose personal information not required for the development of a positive working relationship or for intentional therapeutic purposes (including sharing phone numbers or addresses and friending on social media sites)
- believing only they can offer the right services to a client
- having contact with a client out-of-hours (for example, receiving calls at home from a client)
- increased physical contact or touch with a client
- commencement of intimate or sexual relations with a client
- reluctance to disclose aspects of the relationship with a client in regular supervision

It is also important to remember that many young people only have a basic or developing understanding of the "conventions" of help-seeking behaviour. They may not know the difference between a "normal" or "abnormal" professional relationship, as opposed to most adults who understand the basic convention of treatment or support. Having stated this, this does not mean that you automatically know what a professional relationship is as soon as you become an adult. However it does suggest that workers need to be extra conscious as to how each young person conceptualises the relationship, and to explore this using examples wherever possible to maximise clarity of understanding.

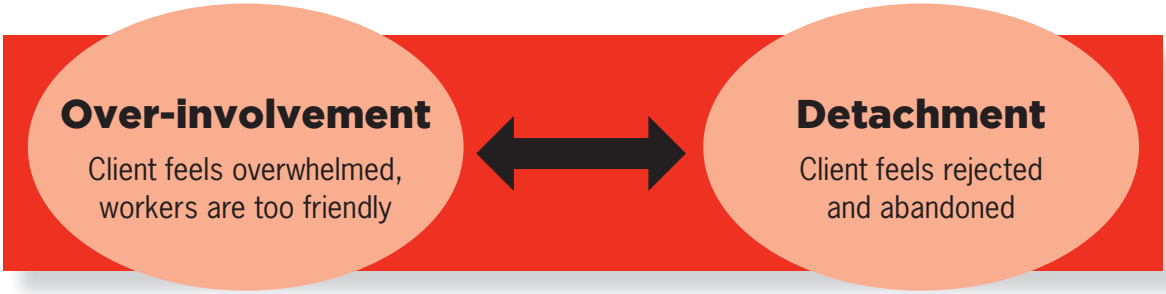

Figure 3: Over - involvement / detachment continuum
Source: Communtiy Door e-Training resource: Work within a legal and ethical framework, http://legacy.communitydoor.org.au

It is not uncommon for young clients to ask their workers whether or not they drink or have taken drugs in the past. This is perfectly understandable, given the judgement or treatment many substance-users face in the broader community. Clients often want to know that their worker has some form of understanding of what they are going through before they invest too heavily in a therapeutic relationship

Some strategies for managing and clarifying boundaries

- Explicitly stating the professional boundaries of the relationship during initial contact, including:
  - clarity about your role,
  - approved modes and times of contact,
  - explaining the difference between being "friendly" and being a "friend" and
  - using examples of what would be appropriate or inappropriate behaviour.
- Questioning or exploring the client's conceptualisation of boundaries when clients ask for personal information.
- Not responding or declining to respond to comments (or behaviours) of a client that may deliberately be seeking a response not consistent with the working relationship (for example, wanting approval or affirmation around particular types or levels of alcohol or drug use).
- Discussing any worries and concerns you begin to have with appropriate people, e. g., professional supervisor, manager, a respected peer.

The following are drawn from Sercombe (2010, 88-89):

- Be open with your peers about the potential for role conflict so as to promote early noticing and discussion of issues.
- Use regular supervision as an opportunity to explore challenges and tensions. Watch out for relational aspects of your work that you are reluctant to talk about in your regular supervision. These might be clues that something needs to be attended to.
- In practice contexts where particular dual roles are commonplace develop policies and procedures which make good practice clear for everyone.
- Where you can't develop and maintain a clear professional role with a young person seek guidance and withdraw from that relationship, whilst facilitating other support for the young person.
- Wherever possible use a team approach when working with young people. This can assist in reducing role confusion.

Blurred professional boundaries are often only first recognised by a manager or colleague, or when a client begins to act in over-familiar ways that retrospectively alert the worker that his or her boundaries have become diffuse. Reeling the relationship back in can be difficult in these circumstances, and may result in altered arrangements including the termination of the therapeutic relationship altogether by either the client or the worker.

It is recommended that organisations offer professional supervision for their staff and implement case-review processes which build workers' capacity for critical self-analysis.

There are various Professional Boundary activities in 'Drilling Down 7' at the end of this Guide.

6.5 Guidelines

Guidelines are generally just that: designed to help guide practice rather than instruct practitioners on what to do in a specific situation. There are an **ever increasing range of guidelines for different settings and aspects of practice.** As such the guidelines that are best to draw on will change over time and according to the practice situation. You will notice that guidelines are often a combination of broad good practice information and quite specific information relating to a particular issue, practice setting and/or target group. See the Guide on 'Practice Strategies and Interventions' in this series for more information.

Be aware that some endorsed regulatory policies of governments are now being referred to as a *Guideline*, not the same thing as practice guidelines.

6.6 Ethical practice and culture

There has been increasing recognition that approaches to ethical practice must include a strong emphasis on **cultural sensitivity**. Figure 4 below is one depiction of how principles, values and relationships weave together to foster trust and ethical engagement in Aboriginal and Torres Strait Islander research. This has great relevance for areas of practice other than research.

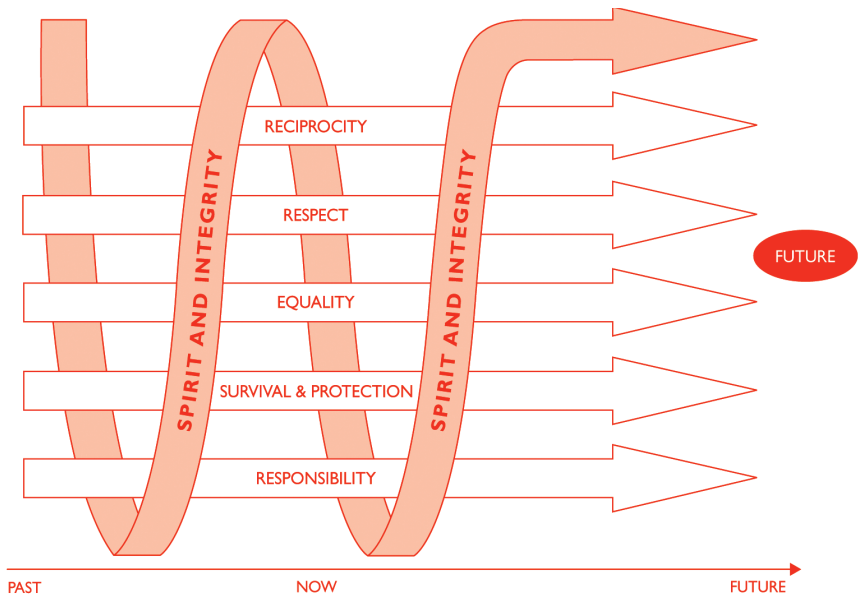

Figure 4: Aboriginal and Torres Strait Islander Peoples' values relevant to health research ethics
Source: National Health and Medical Research Centre (NHMRC), 2003. Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research. 9. [www.nhmrc.gov.au]

Unethical behaviour need not always be a glaring act or infraction. It often includes subtle or only sub-consciously intended encroachments on values and principles. Yet these can significantly erode trust. Similarly, it is often through many small personal interactions that trust is built. Researchers need to consider, as an integral part of the research enterprise, that trust and ethical behaviour are not just about rules but also about discretion and judgement – both complex and challenging matters.

Source: National Health and Medical Research Centre (NHMRC), 2003. Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research. 3. [www.nhmrc.gov.au]

The *Inclusive Model of Ethical Decision Making* (Chenoweth and McAuliffe 2012) outlined in the next section of this Guide has cultural sensitivity as a core element.

Remember, **practice is not culturally neutral**. We all have culture, the implication being that cultural sensitivity starts with understanding our own cultural perspectives and values, then thinking about how these interact with the cultural setting we are working in. In terms of AOD work with young people who have a different cultural location to ourselves it is important that every step of a practice process actively appreciates cultural aspects of the situation.

Drawing on a study of frontline social workers by Yan (2008) there are a number of **cultural tensions** that can exist in direct practice including:

- Many values of direct practice reflect historical roots in an Anglo-American culture. This means practice can be experienced as a form of tension between clients and the 'dominant culture' represented by individual workers or organisations.
- Tensions and conflicts between the culture of an organisation and that of a worker, particularly for workers from a minority culture.
- The cultural values of different professional groups can be at odds with each other.
- Particular areas of professional practice categorise human growth and development as normal or 'not-normal' and develop interventions accordingly. These categorisations and interventions can be ethno-centric and culturally blind.
- Tension arising from ethno-cultural differences between workers and ethno-culturally different clients.

There is no simple list of tips to provide here. Workers and services need to adopt a culturally communicative and reflective approach to service development and delivery as a core and ongoing feature of their work. Making the cultural dimensions of practice a regular focus of discussion within the organisation and across networks helps to deepen understandings and improve cultural sensitivity.

Section 7

Integrated approaches to decision making

Every day practitioners are faced with a myriad of practice decisions large and small, some involving their direct engagement with clients, with other agencies, and with colleagues or other sections of their own agency.

7.1 'Designing in' ethics

In contemporary applied ethics there is a shift away from thinking in simple dualisms ('do I or don't I?') and dilemmas (choosing between two competing options or principles). The reason for this is that most challenging practice situations contain a variety of stakeholder considerations and possible process pathways. Practice approaches develop over time. Being ethical means **thinking ahead about what issues might crop up** in a particular practice environment and 'designing in' possibilities and options that are ethical.

'Designing in' ethics means asking:

How can we redesign the option set such that there is another option C- an option that is additional to the currently existing options A and B? Crucially, option C meets all our ethical requirements and does not force us to choose between them (Miller 2009, 188).

In practical terms this means **identifying the ethical challenges we are most likely to face** in a particular practice situation and proactively developing options and processes which give greater capacity to work ethically when those challenges crop up.

The following experience of an AOD worker, previously reported in Section 1.1, shows how a difficult ethical dilemma was responded to in a way that maintained harm reduction and wellbeing goals, whilst having due regard for the needs of other clients and staff.

There is a 20 year old girl who is a regular paint sniffer who we have had to ban. We virtually never ban so this is big - but her emotional regulation stuff is so variable and she becomes so disruptive that we have to do something. We have a great relationship with another service and she goes there when she is banned here. We make sure she is not banned from both services at the same time and up support to the other service in creative ways to help them maintain her with that service. We will also fund her to return to distant but supportive family where there are other supports when everyone is getting burnt out.

7.2 The inclusive model of ethical decision making

The "Inclusive Model of Ethical Decision Making" (Chenoweth and McAuliffe 2012), developed for social work and human services practice, uses a 5 step process where four key dimensions are constantly revisited (see Figure 5).

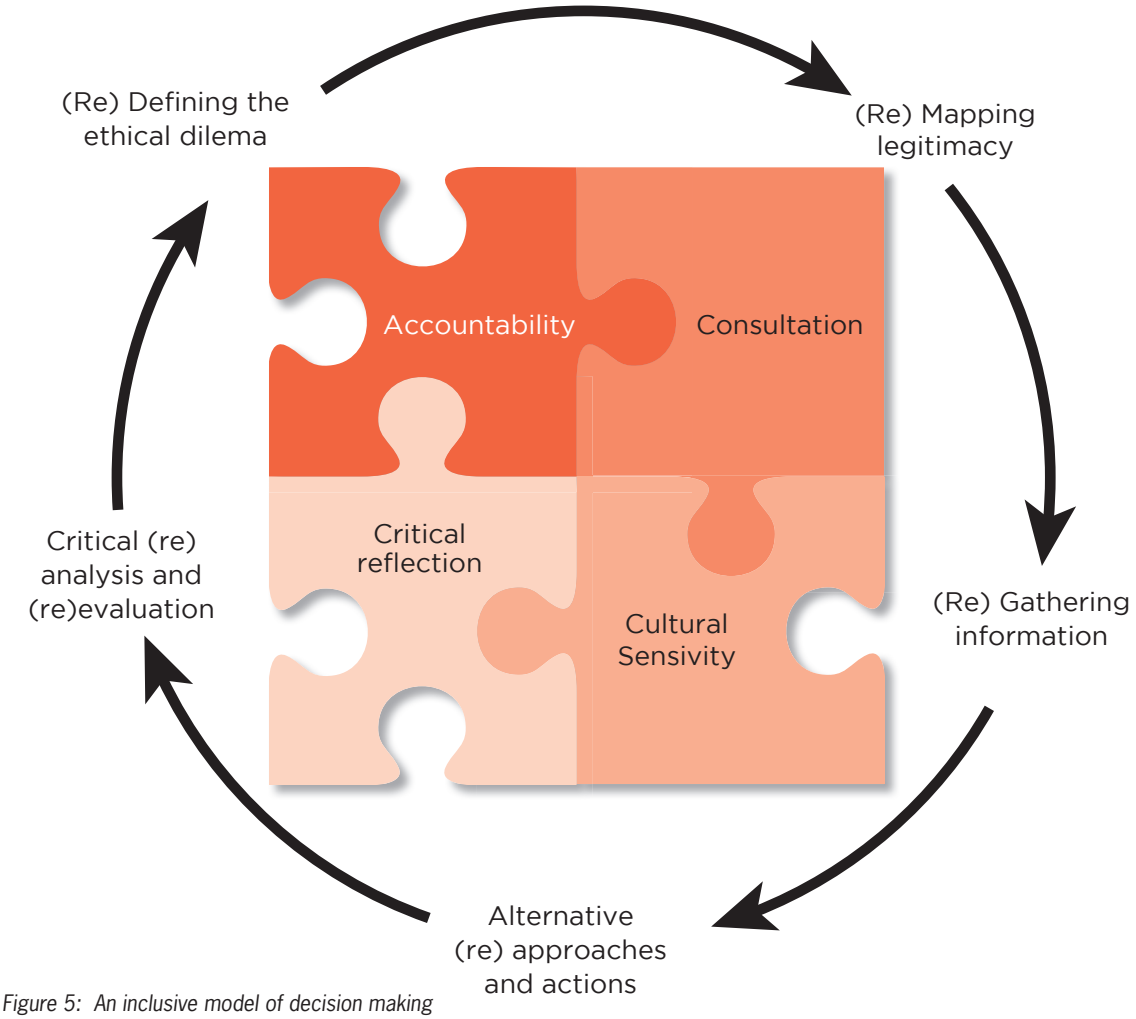

Figure 5: An inclusive model of decision making
Source: Chenoweth and McAuliffe (2012, 123) (reproduced with permission)

The 5 steps of the model are:

- defining the ethical issue or dilemma
- mapping legitimacy
- gathering information
- generating alternative approaches and actions
- critical analysis and evaluation

At each of these steps the four dimensions of accountability, consultation, cultural sensitivity and critical reflection are used to explore and develop a rich understanding that can be used to assist decision making. Each of these steps can be revisited several times as new information and reflection expands understanding.

The following table provides some generic questions for each step of this process.

Whilst there may not be time to apply this model to every practice situation, workers should regularly 'unpack' their practice in detail. This model can assist.

Table 7: Generic questions for an inclusive decision making process

STEP	QUESTIONS
Define the ethical issue or dilemma What is the worry / tension? Is there a clear course of action even though it may be difficult for you in some respect? (In which case you don't have a dilemma!)	*Accountability:* Is it my role to make a decision, or should it be referred to someone else (e. g., supervisor?) *Consultation:* Do I need to consult with someone else to clarify how I am thinking about this? *Cultural Sensitivity:* Are there issues of cultural sensitivity I need to take account of? *Critical Reflection:* What have I learnt previously about this type of situation? Can I state what the dilemma is for me?
Map legitimacy Who are the legitimate people / agencies in this situation?	*Accountability:* Who has legitimate interests in this that should be respected? *Consultation:* Is it appropriate to share this dilemma with others? Who should I be talking to at this stage? *Cultural Sensitivity:* Are there cultural factors to take into account? *Critical Reflection:* What basis am I using for deciding who is legitimate in this?
Gather information What information might help you work out what to do?	*Accountability:* What guidance is provided by laws, policies, practice standards, codes of ethics, guidelines? *Consultation:* What other information might assist? Are there other resources that could shed light on this? Who else should I ask for guidance? *Cultural Sensitivity:* Might there be specific cultural knowledge needed and who should I consult with? *Critical Reflection:* Are there conflicts between personal, professional, organisational and legal expectations? What are they?
Generate alternative approaches and actions What are the options?	*Accountability:* What are the options? On what basis will I make this decision? *Consultation:* Who can I talk about this with to check my reasoning? *Cultural Sensitivity:* Are any of these options culturally insensitive or culturally safe? *Critical Reflection:* Can I live with this decision? Can I justify it if needed?
Critically analyse and evaluate What happened? What does this mean? What are the implications?	*Accountability:* Are there issues or implications for the future / for policy that I need to raise elsewhere as a result of this? With my supervisor? My organisation? *Consultation:* Did I consult well? Were there others I should have talked to? *Cultural Sensitivity:* Do I feel I acted in a culturally sensitive way or were there gaps? *Critical Reflection:* What have I learnt from this situation? About the content? About how I make decisions?

You can read more about this model in:

Chenoweth, L., McAuliffe, D. 2012. *The road to social work and human service practice.* 3rd ed., South Melbourne: Cengage Learning.

McAuliffe, D., Chenoweth, L. 2008. `Leave no stone unturned: The inclusive model of ethical decision-making? *Ethics and Social Welfare, 2*(1) 38-49.

7.3 Returning to the checklist of questions for decision making

Let's revisit the checklist of basic questions referred to in the first section of this Guide. This checklist contains the types of questions which experienced reflective practitioners may come to canvas intuitively in routine practice situations. In practice situations which are not routine, for less experienced or reflective workers, and for those new to a particular practice context these questions need to be explicitly considered.

Whilst these questions are not exhaustive they will prompt consideration of the legal, ethical, good practice and organisational aspects of a practice situation.

Workers will not have the time to consciously work through this process for every decision they make. But time should be made by workers and their services to regularly work through these considerations in an explicit and structured way so as to build up knowledge and capacity over time. It is too late in the middle of a crisis.

Of the many decision points workers face, some will stick out as very challenging, where the worker realises there are competing considerations that are not easily resolved by applying a single principle, policy or law. It is in these more complex practice situations that it can be useful to use an explicit decision making framework.

Induction of new workers, professional development training, team processes, and professional supervision all provide opportunities for taking a particular practice situation, real or imagined, and identifying and working through the embedded legal and ethical considerations.

The following template may be useful to map your exploration of a particular situation. Use in conjunction with Table 2 in this Guide and the *Inclusive Model of Ethical Decision Making* (Chenoweth and McAuliffe 2012) in Figure 4, both of which provide further prompts so you can 'drill down'. Feel free to adapt and develop this template further so as to best suit your practice context.

Keep in mind

A critical element of working ethically with vulnerable young people is proactively building relationships and options that if used flexibly and creatively allow the broader goals of harm reduction and wellbeing for the young person to remain at the centre of practice.

A template for exploring the legal and ethical dimensions of a practice situation

IN RELATION TO A PARTICULAR PRACTICE SITUATION YOU SHOULD ASK	ANSWERS	WHAT ELSE MIGHT NEED TO BE CONSIDERED/DONE?	SOURCES OF RELEVANT INFORMATION / QUESTIONS TO FOLLOW UP ON
Outline a scenario to examine. Add detail in as you explore so as to best reflect the complexity of practice			
What aspects of this situation do I need to make a decision about?			
In respect of each of these aspects (or together if relevant) answer the questions below:			
What is my role and mandate?			
What does the law say?			
What does my organisation (policy and procedures) say?			

IN RELATION TO A PARTICULAR PRACTICE SITUATION YOU SHOULD ASK	ANSWERS	WHAT ELSE MIGHT NEED TO BE CONSIDERED/DONE?	SOURCES OF RELEVANT INFORMATION / QUESTIONS TO FOLLOW UP ON
What does my professional framework say? -practice standards -accepted good practice characteristics & strategies -core values -code of ethics -ethical decision making processes			
What does my personal framework say?			
What impacts might my decision / approach have on my client? On others?			
What other processes should I use to inform what I do?			
What else should I consider here?			
On what grounds can I justify what I do?			

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Drilling Down 1

RESOURCE	FOCUS	SOURCE
Guide to Informed Decision Making in Healthcare	Informed consent in health services	www.health.qld.gov.au/consent/documents/ic-guide.pdf
Fraser Guidelines / Gillick Competency Checklist	A UK checklist used as guidance for practitioners in determining and recording their decision as to whether a young person is able to consent to treatment.	Download the check list from the site below via the search function. www.doncaster.gov.uk
Health Services Act 1991 (Qld) Confidentiality Guidelines	Outlines confidentiality requirements for practitioners and officers covered by the Act	http://www.health.qld.gov.au/foi/docs/conf_guidelines.pdf
Guidelines for Independent Children's Lawyers	It may be useful for AOD practitioners to understand the role and principles for lawyers representing children in matters.	Download via the search function from www.nla.aust.net.au
Queensland Legislation	All Queensland Acts of Parliament and Regulations	www.legislation.qld.gov.au/OQPChome.htm
Queensland case law	All Queensland court information	www.courts.qld.gov.au
Legislation and case law generally	General legal information	www.austlii.edu.au www.comlaw.gov.au

Reporting on young people in the media	Particular legal provisions around young people in care and in contact with the youth justice system	www.ccypcg.qld.gov.au/pdf/publications/brochures/children-and-the-media/Corporate-Fact-Sheet1.pdf
The Queensland Law Handbook 11th Edition 2011	A new edition is published approximately every two years. Very readable and informative.	Available only in printed form from Caxton Street Legal Service at www.caxton.org.au
Laying Down the Criminal Law (3rd Ed)	A handbook for youth workers. Very useful information and scenarios.	Available from the Youth Advocacy Centre www.yac.net.au
Australian Review Council Best Practice Guides	A series of Guides to assist in decision making Guide 1—Decision Making: lawfulness Guide 2—Decision Making: natural justice Guide 3—Decision Making: evidence, facts and findings Guide 4—Decision Making: reasons Guide 5—Decision Making: accountability	Available in Publications at: www.ag.gov.au/agd/WWW/arcHome.nsf
The Australian Medico-Legal Handbook	Explanation of how the law applies to medical practitioners and health care providers	Only in printed form

Drilling Down 2

What are the different types of law?

There are various types of law which have relevance for youth AOD practice. Here is a quick walk through the various types of law according to key criteria, and how they are relevant to youth AOD practice.

- Who 'makes' the law? Statute law (made by Parliaments) and Common law (made by judges)
- The jurisdiction of the law? Australian, each State/ Territory law (domestic)and international law
- Whether it pertains to public or private matters (Public and Private law)
- What the law regulates? (Civil law and Criminal law)
- How is executive government power controlled and supervised? (Administrative law)
- Whose system of law is recognised? (Aboriginal and Torres Strait Islander Customary law is recognised in some situations).

Common law comprises common law principles and precedents and involves interpretation of the law by courts. Common law can be overridden by statute law unless that statute law is ruled 'unconstitutional'. The Gillick principle is an example of common law relevant to youth AOD practitioners.

Statute law comprises Acts of Parliament and Regulations made by a Parliament with a particular jurisdiction (National, State or Territory). Local governments under an Act of State parliament are able to make Local laws (or Bi-laws). Statute law also establishes health policy and service systems.

Criminal law is a particular form of Statute law underpinned by notion of the establishment and continuity of public order, where a hierarchy of offences and penalties are defined by the state. These may change over time (the process of certain things being 'criminalised' or 'decriminalised').

Criminal law in Queensland and Australia makes the procurement and/or possession of particular drugs and associated implements illegal except in particular circumstances, for example purchasing alcohol under the age of 18.

Such illicit status of AOD use creates a range of legal and ethical considerations for practitioners, including how to manage the tension between the illicit nature of some drug use and the endorsed policy objective of reducing harm from such use. Add in the client being a young person whose legal status can be variable or unclear, in practice settings which are voluntary, and the practitioner has some significant challenges. What approach to take to drug use, in law, is a subject of some debate. Wodak (2007) distinguishes between 'wrong in itself' laws and 'wrong by statute' laws. Wodak suggests drug laws are in this second category.

'Wrong in itself' laws 'tend to involve violence, are generally very consistent from one jurisdiction to another, witnesses are often readily available (making prosecution easier), and the laws are fairly stable and are generally not controversial'. 'Wrong by statute' laws 'in contrast tend to involve consensual and non-violent activities, are very inconsistent from one jurisdiction to the next, witnesses are rarely available (making prosecution difficult) and the laws are often unstable and controversial'.

Source: Wodak 2007, 61.

Public Law applies to the behaviour of all citizens, such as law relating to fund raising, and includes what human service workers specifically are required to do or not to do. Mandatory reporting of suspected child abuse by some categories of workers is an example.

Civil Law covers everything that is not a crime.

Contract law has become increasingly important through the 'purchaser- provider' split between government funding and service delivery, service agreements, MOU's between agencies and staff employment contracts.

Tort law concerns claims people make against others such as negligence, defamation, nuisance and trespass.

Administrative law applies to how various authorities exercise powers and discretions, and particularly that they follow certain principles in making decisions. Another way to put it is that administrative law relates to the application of a policy to a particular circumstance.

As the distinction between public and private bodies blurs, this area of law is developing quite rapidly (Kennedy 2009) and agencies delivering health and community services must be mindful of these requirements.

There is some limited recognition of **Aboriginal and Torres Strait Islander Customary law** in Australia, through recognition of native title as well as in criminal law. Courts may have the discretion to take into account Aboriginal customary law as a mitigating factor in sentencing (Law Reform Commission NSW 2000).

Each of these types of law is relevant to youth AOD practice in some way.

Civil law conditions behaviour in a jurisdiction more broadly.

Contract law governs how services are delivered. Funded service agreements with governments, and often with funds from philanthropic sources are one example. Contracting may also be relevant at the service delivery level through written agreements between services and clients.

Individuals can take a civil action alleging negligence on the part of a person, agency or entity, under what is called **Tort law.**

Public law requires all people to adhere to certain behaviours and rules in a wide range of matters. How should food be handled? How can products be sold? How should fund raising be undertaken? Many of these provisions affect how health and community services are delivered.

Courts, tribunals, youth justice conferencing and associated AOD programs

Youth AOD practitioners need to have a working knowledge of what courts and tribunals their clients might be engaged with and the implications of this for their practice.

It is the role of courts to apply the law and given laws are expressed in language, it is also their role to interpret what the law means (see Common law above). There are Federal and Queensland courts and tribunals, with the High Court of Australia being the highest court of appeal in Australia. Figure 5 below depicts the court and tribunal structure for Queensland. Queensland's Court system comprises three main tiers alongside a range of specialist courts and tribunals.

Most significantly for Queensland, a range of small and medium sized tribunals were abolished in 2009 and replaced by the single Queensland Civil and Administrative Tribunal (QCAT) [www.qcat.org.au]. The QCAT deals with a wide range of matters including anti-discrimination matters, small claims, children and young people matters, residential tenancy disputes, building disputes and disciplinary action in relation to a number of professions, amongst many others.

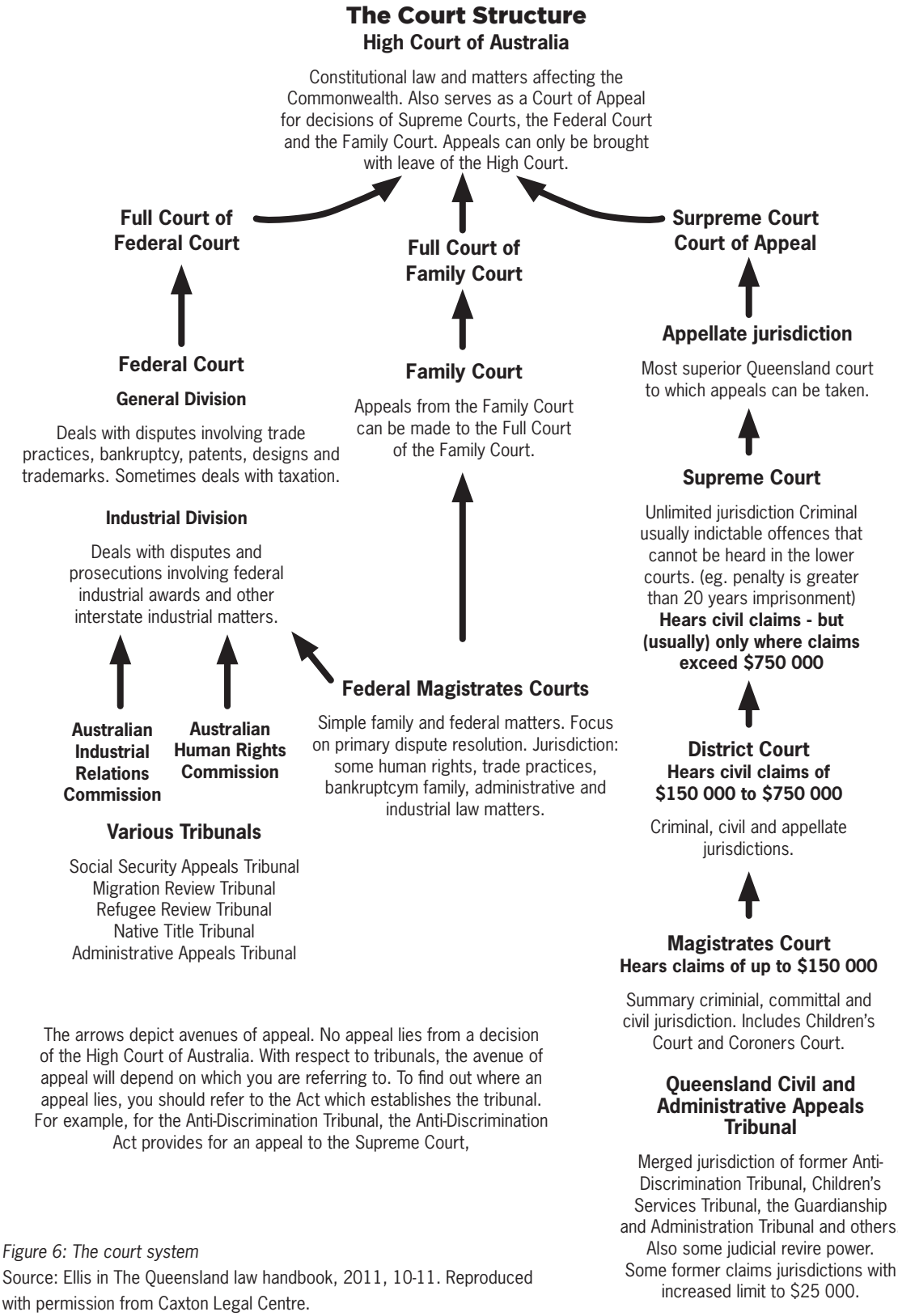

Figure 6: The court system

Source: Ellis in The Queensland law handbook, 2011, 10-11. Reproduced with permission from Caxton Legal Centre.

Childrens Court of Queensland (Magistrates Court)

The following text is taken from the Queensland Courts website at www.courts.qld.gov.au

Magistrates Court matters involving juveniles (people under the age of 17) are dealt with in a special court known as Childrens Court.

Childrens Court matters are heard in a closed court. This means only those directly involved in the case may be present and no one is permitted to publish any information which can be used to identify the defendant.

Childrens Court matters include:

- Youth Justice – proceedings involving juveniles who commit or are alleged to have committed offences
- Child protection – proceedings relating to applications by the Department of Child Safety regarding the protection of children from harm
- Applications to dispense with consent of parent to adoption – proceedings where a parent's identity is unknown or they cannot reasonably be found

Source: Queensland Government. 2012. "Childrens Court of Queensland (District Court)." [www.courts.qld.gov.au/courts/childrens-court-of-queensland]

Childrens Court of Queensland (District Court)

The Childrens Court of Queensland (CCQ) deals with all juveniles who commit criminal offences while under the age of 17 years, unless the court orders that the matter be dealt with in an adult court.

Matters involving children can be heard in the adult District Court of Queensland if:

- the child is charged as an adult
- the proceedings have been committed up to the District Court following an application under the *Youth Justice Act* 1992 *(www.legislation.qld.gov.au/LEGISLTN/CURRENT/Y/YouthJustA92.pdf),* for example, if a child is co-accused with an adult

CCQ matters are also usually heard in a closed court. The CCQ is presided over by judges who have been appointed from the District Court. Matters are heard in accordance with the guidelines set down in the:

Childrens Court Act 1992

(www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildrensCtA92.pdf) and the

Youth Justice Act 1992

(www.legislation.qld.gov.au/LEGISLTN/CURRENT/Y/YouthJustA92.pdf).

Source: Queensland Government. 2012. "Childrens Court of Queensland (District Court)." [www.courts.qld.gov.au/courts/childrens-court-of-queensland

Youth justice conferencing

Youth justice conferences have become an important alternative in some cases to determination by a Children's Court.

When a young person admits to an offence the police may make a conference referral instead of sending the matter to court. In some cases, a court will request that a youth justice conference takes place. A conference convenor helps everyone talk through what happened and how everyone has been affected.

A youth justice conference is a meeting facilitated by a convenor. A conference brings the young person and their family together with the victim (if they wish to attend) as well as a police officer. The aim of a youth justice conference is for the victim, the young person and their family to come up with an agreement about how the young person can begin to repair the harm caused by the offence.

The purpose of the conference is to:

- provide a safe, supportive environment to talk about what happened and to work out what the young person should do to put things right,
- hold the young person accountable for their actions,
- find ways to help repair the damage or harm that has been caused to the victim of the offence,
- involve the victim, the young person's family and the young person, and themselves in making decisions about what should happen to repair the harm that has been caused.

Source: Queensland Government. 2011. Youth justice conferencing for victims, young offenders, and families. [www.communities.qld.gov.au]

Coroners Court

The Coroners Court is a particular type of Magistrates Court established under the *Coroners Act* 2003. Coroners are responsible for investigating reportable deaths that occur in Queensland. A reportable death is a death where:

- the identity of the person is unknown
- the death was violent or unnatural, such as accidents, falls, suicides or drug overdoses
- the death happened in suspicious circumstances
- a 'cause of death' certificate has not been issued and is not likely to be issued
- the death was a health care related death
- the death occurred in care
- the death occurred in custody
- the death occurred as a result of police operations

Reportable deaths are usually reported to the coroner by police. When a death is reported the coroner investigates the death to find out the identity of the deceased person, when and where they died, how they died and the medical cause of death. If a coroner decides to hold an inquest the coroner can make recommendations aimed at preventing similar deaths in the future. Coronial investigations do not focus on laying blame or assigning liability for the death.

Coroners will take into account family and cultural concerns when making decisions about the deceased, such as the extent of the autopsy.

If you need information about the status of a coronial investigation, please contact the coroner's office. If you are unsure which coroner is handling an investigation, contact the Office of the State Coroner

(http://www.courts.qld.gov.au/contact-us/office-of-the-state-coroner) for further assistance.

Source: http://www.courts.qld.gov.au/courts/coroners-court

The State Coroner's Guidelines (2003) current at the time of writing indicates the following in respect of violent or 'unnatural' deaths.

Specific causes of unnatural deaths can be divided into three broad categories:

- acute effects or intoxication with chemicals (e.g., alcohol, drugs, poisons)
- deprivation of air, food or water (e.g., asphyxia, drowning, dehydration, starvation)
- physical factors (e.g., trauma, fire, cold, electricity, radiation)

Deaths where neglect or inadequate or delayed treatment have, or may have, contributed to the death should be reported and arguably may be regarded as "unnatural" under the "deprivation" category.

Source: http://www.courts.qld.gov.au/__data/assets/pdf_file/0004/84919/state-coroners-guidelines.pdf

Services and workers involved in AOD related practice can find their practice under scrutiny as part of a Coronial investigation. Practices which will assist in this include:

- team / management support in case planning and case work;
- ensuring that agency policy and procedures are robust, reviewed regularly, reflect appropriate standards and are well founded;
- keeping good case notes particularly around decision points and managing risk.

Queensland Drug Court

The Queensland Drug Court is a Magistrates Court established to specifically deal with the sentencing of adults (defined as 18 years and over in Queensland) who are drug dependent and where their offence was committed to support their illicit drug use. The following information is from the Queensland Health ATOD web site.

> *An offender who meets certain eligibility criteria may have the sentence suspended and be provided with the opportunity to undertake a rehabilitation program under an Intensive Drug Rehabilitation Order (IDRO) as an alternative to prison. The eligibility criteria and disqualifying criteria are documented in the Drug Court Act 2000 and the Drug Court Regulations 2006. There are Drug Courts in Beenleigh, Ipswich,*

Southport, Cairns and Townsville.

Drug Courts aim to help offenders overcome their drug dependence and associated criminal behaviour through court enforced and supervised rehabilitation programs. On referral to the Drug Court Program, the offender must be willing to undergo assessments by staff from Queensland Health and Queensland Corrective Services (QCS) to determine their suitability for rehabilitation. Once on an IDRO, a person must abide by the strict terms and conditions set by the Court including participation in treatment and QCS Probation and Parole directed rehabilitation programs.

Queensland Health provides operational, assessment and treatment support to the Drug Courts in accordance with the legislation. Queensland Health also supports the Drug Court Program by providing treatment services through Alcohol, Tobacco and Other Drug Services on the Gold Coast, Southside, West Moreton, Cairns and Townsville Health Service Districts, and through services purchased from the non-government sector.

Source: Queensland Government. 2012. "Queensland drug court program (alcohol tobacco and other drugs)." [www.health.qld.gov.au/atod/treatment/qld_drugcourt.asp]

Other Queensland Drug Diversion Programs

There are also a variety of drug diversion programs operating in Queensland which youth AOD practitioners need to have an understanding of. The information below is provided from the Queensland Health ATOD web page at www.health.qld.gov.au/atod

- **Police Diversion Program**

The Police Diversion Program is provided for under Section 211 of the Police Powers and Responsibilities Act 2000. People who are found by a Queensland Police Officer in possession of 50 grams or less of cannabis, and who meet the strict eligibility criteria, are offered to be diverted from the criminal justice system to an assessment and education session. The Police Diversion Program commenced in June 2001.

People identified as dependent on cannabis are referred at the completion of the session to the closest agency with treatment services for cannabis dependence. Where appropriate, referrals to other drug and alcohol and/or other services are also made. Participation in further treatment is voluntary.

There are strict eligibility criteria which must be met before someone is offered diversion by the police. Not all people found with 50 grams or less of cannabis are eligible.

A person is eligible if they:

- are arrested for, or questioned about, a minor drugs offence (i. e., possession of not more than 50 grams of cannabis or possession of a thing for use, or that has been used, for smoking cannabis),
- have not committed another indictable offence in circumstances related to the minor drugs offence,
- have not previously been convicted of an offence involving violence against another person,
- admit having committed the offence during an electronically recorded interview,
- have not been offered diversion on a previous occasion.

- **Illicit Drugs Court Diversion Program**

The Illicit Drugs Court Diversion Program is aimed at diverting all eligible offenders who appear in Magistrates Courts or any Queensland Children's Magistrates Court charged with possession of a small amount of an illicit drug for personal use.

The Program is conducted under a legislative framework specified in the Drug Diversion Amendment Act 2002, and commenced in March 2003.

Magistrates in the courts are permitted to sentence eligible and consenting offenders pleading guilty to offences of possession of a small quantity of drugs and/or utensil to a recognisance with a condition that the offender attends a drug assessment and education session. Session attendance means that a conviction is not recorded. If a diverted offender fails to attend the designated drug assessment and education session, they are returned to court to be dealt with again for the original offence.

As with the Police Diversion Program, diverted offenders who are identified as having a dependence

on an illicit drug are also offered a referral to an authorised provider of outpatient treatment programs.

In the case of juvenile offenders, the court proceedings are adjourned while the young person attends the session. If they successfully complete the assessment and education session, a finding of guilt is made against the young person but no conviction is recorded nor any further action taken. If the young person fails to attend the session, they are returned to court for the Magistrate to determine sentencing.

A person is eligible to be offered the opportunity to attend a drug assessment and education session if they:

- *are charged with an eligible drug offence*
- *appear before any Queensland Magistrates Court*
- *have not previously been convicted of (or are currently facing) charges of a sexual nature or a drug offence dealt with on indictment*
- *have not previously been convicted of an indictable offence involving violence against another person (other than certain offences specified in the Drug Diversion Amendment Act 2002)*
- *have been offered a diversion on no more than one previous occasion (including Police Diversion)*

An 'eligible drug offence' is an offence against the Drugs Misuse Act 1986, Section 9 (possessing dangerous drug) or Section 10 (possessing things) if the drug and the quantity of the drug and another substance is less than the amount prescribed in a schedule of the Penalties and Sentences Act 1992.

The court must also be satisfied that the dangerous drug or drugs were for the person's personal use.

• Queensland Magistrates Early Referral into Treatment Program (QMERIT)

The QMERIT pilot program commenced operation in Redcliffe and Maroochydore in July 2006. It is a pre-sentence diversion program which is for offenders at an early stage in the criminal justice process, who are willing to assume responsibility for their drug-related behaviour as early as possible in the court process.

The Program allows the court the flexibility to offer offenders the option of voluntary participation in a sustained program of treatment prior to sentencing. Individuals who are charged with drug-related offences are encouraged to undergo assessment and treatment for their illicit drug use problems while they are on bail. A person can be bailed into the QMERIT Program under Section 11 of the Bail Act 1980.

The diversion is based on partnerships of health professionals case managing participants through a treatment regime that lasts approximately four months. Clients formally admitted into the QMERIT Program return regularly to court at the discretion of the magistrate.

The QMERIT Program is tailored to individuals needs. Treatment options may include detoxification, opioid treatment, group programs and residential rehabilitation. A progress update is provided by case workers to the magistrate. Individuals who graduate from the Program are offered the opportunity to participate in an aftercare program where they receive additional support beyond the formal treatment period. Support may include ongoing alcohol and drug counselling, life skills, employment programs, accommodation assistance and parenting programs.

A person is eligible to enter the QMERIT Program if:

- *the offences charged are related to problematic drug use*
- *the offences do not involve strictly indictable offences, allegations of sexual assault or matters of significant violence, and should not have like offenders pending before a court*
- *they have a demonstrable drug problem*
- *they are eligible for bail and suitable for release on bail into the QMERIT Program*
- *they give informed consent to participate in the program*
- *they are deemed suitable for the program (based on results from a clinical suitability appraisal)*
- *they reside in the defined catchment area*

• Queensland Indigenous Alcohol Diversion Program

QIADP offers Aboriginal and Torres Strait Islander people, charged with a summary alcohol-related office, the opportunity to participate in treatment. The program is also available for Aboriginal and Torres Strait Islander parents referred by the Department of Child Safety, whose alcohol use adversely impacts their ability to protect their children.

QIADP has been designed for two groups of Aboriginal and Torres Strait Islander people:

- those charged with an offence where alcohol has been a contributing factor (Criminal Justice stream)
- parents whose alcohol use makes them unable to adequately protect their children (Child Safety stream)

QIADP is being piloted over three years in Rockhampton / Woorabinda, Townsville / Palm Island and Cairns / Yarrabah.

Source: Queensland Government. 2011. "Queensland Indigenous alcohol diversion program."

• Queensland Early Intervention Pilot Project (QEIPP)

Increasingly, alternative approaches to traditional policing responses are being trialled throughout Queensland. One example is the Queensland Early Intervention Pilot Project (QEIPP), which is not a diversion program per se, but rather is in addition to any legislative measures that police undertake. The following overview of QEIPP is taken from the QEIPP Brochure:

What is QEIPP?

The Queensland Early Intervention Pilot Project (QEIPP) is an Australian Government harm minimisation initiative designed to address alcohol misuse among Queensland youth under 18 years of age.

QEIPP recognises that families play an important role in developing the values and behaviours of young people in relation to drinking.

The pilot project concludes on the 31 December 2012.

Where is QEIPP operating?

The intervention is being piloted in the Sunshine Coast and Rockhampton areas and will be implemented in other selected areas within Queensland.

Who is eligible?

Young people under 18 years of age are eligible to participate in QEIPP if:

- Police reasonably believe they are intoxicated by alcohol
- Are found in possession of, or consuming alcohol in a public place

Can I self refer into QEIPP?

Yes, young people and/or their parent / guardian can self refer into an alcohol education awareness session.

Alcohol Education Awareness Session: About the FREE session

The FREE session is designed to explore factors that underlie drinking behaviour and provide avenues for change.

The session will take approximately one hour.

Is the session confidential?

Yes, the discussion with the qualified health professional will be a confidential session.

Only non identifying information will be provided to the Queensland Police Service for the purpose of collecting data for the national evaluation of the project.

Who can attend the session?

QEIPP recommends parents / guardians attend the session with the young person.

Parents/guardians can also choose to attend the session without the young person.

What if the young person does not attend the session?

There is no obligation for the young person to attend the session although they are encouraged to do so.

Benefits

Young people and/or their parent / guardian are given the opportunity to:

- talk to a qualified health professional
- discuss the health effects and legal risks associated with alcohol misuse
- explore / identify factors underlying alcohol misuse which may include mental health issues, family culture and/or peer pressure
- identify factors that may strengthen and improve their relationship with the young person for example communication techniques
- develop an awareness of other services that may assist the young person if necessary.

For police:

- early intervention
- proactively intervene with young people who meet the eligibility criteria
- develop more positive relationships between police, young people and their parents/guardians
- improve alcohol education in families and the wider community
- improving partnerships with Queensland Health and local health service providers.

For more information Email: QEIPP@police.qld.gov.au

Drilling Down 4

The case of Steven

Section 3.1 of this Guide contained a case study about the young person Steven, who is staying at the youth shelter where Sharon is employed as a youth worker. The following text analyses the legal dimensions of this case study. What legal issues and information should Steven and Sharon be aware of?

The text below is reproduced with the kind permission of the Youth Advocacy Centre and comes from Laying Down the Criminal Law: A handbook for youth workers (Wight and Hoyer 2009, 11).

Steven is a 15 year old boy who is staying at the Harvest Youth Shelter. He left home a couple of days before, apparently because of hassles with his stepfather. Steven is not attending school and is unable to maintain himself. The police come to the Shelter and ask to see Steven, who is out when they call. They say that he is suspected of involvement in drug related matters and search his room. They find nothing but tell Sharon, the youth worker on duty, to call them when the young person returns to the shelter.

On Steven's return, Sharon tells him the police want to see him about a drug related matter and that they searched his room. Steven says that he does have a small amount of marijuana on him, given to him by a friend, but that is all. Sharon reminds him that he should not have drugs in the shelter, so Steven gives the marijuana to Sharon. There is some drama occurring down the hallway so she puts the marijuana in the drawer of a filing cabinet in the office and locks it.

Later that evening, Steven's stepfather telephones to say that the police have said Steven is staying there, accuses the workers of "kidnapping" Steven and says that he, the stepfather is coming to get him.

Legal Issues

STEVEN

The police have the power to search his room without a warrant under the *Police Powers and Responsibilities Act* 2000.

Steven does not have to make contact with the police. However, Steven needs to be aware that the police may arrest him for questioning.

This means he must go with the police, however he does not have to answer any questions because he has the right to remain silent, except for providing his name, age and address.

If he does make contact with the police he has the right to remain silent except for providing his name, age and address.

If he decides to participate in a recorded interview, he is entitled to have a support person present.

Possession of marijuana is an offence in Queensland therefore Steven is committing an offence by having marijuana in his possession.

By giving the marijuana to Sharon, Steven has committed an offence of supplying dangerous drugs.

Steven's grandfather has no legal rights with respect to Steven if he does not have guardianship. If Steven's stepfather had guardianship of Steven, there would be a court document that states this. If he is not Steven's legal guardian, he can not force Steven to go with him.

Steven is able to make decisions about leaving home if he is Gillick competent. If Steven is Gillick competent, even if his stepfather does have legal guardianship, he can not be forced back home. If he appears to be at risk of harm, Child Safety Services may take him in to care.

SHARON

The police may search Steven's room without a warrant.

It would be advisable for Sharon to stay with the police during any search.

Sharon does not have to answer any questions asked by police except to give her name, age and address.

If Sharon decides to talk to police it is important that she not lie or mislead them as this is an offence of obstruct police.

Sharon does not have to inform police when Steven arrives back at the shelter. When informing Steven about the police visit, Sharon should do so in such a way that she can not be accused of obstructing police or assisting Steven to avoid police.

Since the owner / occupier of premises can be guilty of an offence if drugs are found on them; Sharon needs to ensure house rules on drugs at the shelter

are enforced and clearly stated to young people when being inducted.

By accepting the drugs, Sharon is also in possession as she has taken control of them. Sharon could be charged with possession of a dangerous drug. She must not take them from the young person but should remind him that he cannot bring drugs on to the premises.

Sharon does not have to tell the stepfather, irrespective of whether he is Steven's legal guardian, if Steven is staying there.

A worker should not actively encourage a young person to leave home; this can be seen as abduction of a child.

Policy and Practice Issues

What is your agency policy / your view on:

- Contact with police?
- Contact with parent / guardian?
- Contact with persons who have no legal ties with a young person?
- Drugs being brought on to the premises? Does the agency have consequences for being found with drugs on the premises and how is this policy communicated to users of the service?
- Administering legal drugs?

Possible consequences and outcomes

By accepting the drugs, Sharon is committing an offence and is putting the agency at risk as the owner / occupier could not now dispute knowledge of the presence of the drug.

The police are likely to keep looking for Steven if he does not go to the police station. Steven could see a solicitor and have them contact the police on his behalf to see what they wish to discuss and possibly arrange a time that Steven and the solicitor could attend at the police station. This would give Steven more control over what is happening and ensure he has someone with him during any contact with the police.

If Steven decides not to return home, there are issues about his longer term accommodation and income needs. If these are not addressed, he may be at risk of intervention by Child Safety Services or possibly the youth justice system if his solution to accommodation and income needs lead to him breaking the law, e. g., squatting, stealing food / money for food.

Consider the general principles of Convention on the Rights Of the Child (CROC). Are there any other Articles relevant to this scenario?

Consider / Discuss

Would you deal with the situation any differently if:

- Steven was 13?
- The person concerned was female?
- Steven had heroin rather than marijuana?
- Steven had a prescription drug rather than marijuana?
- If so how and why?

Resources for informing ethics in practice

RESOURCE	AVAILABLE FOR DOWNLOAD AT
Alcohol and Other Drugs Council of Australia AOD Code of Ethics (2007)	www.adca.org.au
Australian Association of Social Workers Code of Ethics (2010)	www.aasw.asn.au
Australian Community Workers Association Code of Ethics (2011)	www.acwa.org.au
Australian Psychological Society Code of Ethics (2007)	www.psychology.org.au
Is it OK? An on-line kit developed by YAPA in NSW.	www.yapa.org.au
Guide to Informed Decision Making in Healthcare (Queensland Health)	www.health.qld.gov.au
National Health and Medical Research Council National Statement on Ethical Conduct in Human Research	www.nhmrc.gov.au
Nursing and Midwifery Board of Australia	www.nursingmidwiferyboard.gov.au
Public Sector Ethics Act 1994 *(Qld):* Summary of Key Provisions, and Resources	www.ethics.qld.gov.au
Communtiy Door e-Training resource: *Work within a legal and ethical framework*	http://legacy.communitydoor.org.au
Youth Action and Policy Association (YAPA) Code of Ethics for Youth Work	www.yapa.org.au

Child protection professional education resources and assessment tools

A number of **child protection professional education resources and assessment tools** are available. The Child Safety Education module and Self Assessment of Capability tool are intended to support health professionals in relation to their responsibilities, ability to recognise, and confidence to report suspicions of child abuse and neglect.

Child protection resources

RESOURCE	AVAILABLE FOR DOWNLOAD AT
Child Abuse and Neglect Education Module	www.health.qld.gov.au/child-youth/docs/Module1.pdf
Capability Self Assessment Tool	www.health.qld.gov.au/child-youth/docs/self_assess_cap_tool.pdf
Peak Care Navigating Child Protection System resources	www.peakcare.org.au/training/resources/navigating-the-child-protection-system
Child Protection Induction Kit	www.peakcare.org.au/training/resources/cp-induction-kit
Information Kit on Child Protection for Workers	www.communitylegal.org.au

Agencies which play a key role in child protection

AGENCY	ROLE	WEB SITE
Department of Communities Child Safety and Disability Services	The Department with statutory responsibility for child protection in Queensland	www.communities.qld.gov.au/childsafety/
CREATE Foundation	NGO representing the interests of young people in care. Advocacy and research role	www.create.org.au
Commission for Children and Young People and Child Guardian(CCYPCG)	The CCYPCG promotes and protect the rights, interests and wellbeing of children and young people in Queensland, particularly those who are in care or detention, have no one to act on their behalf, are not able to protect themselves, or are disadvantaged because of a disability, geographic isolation, homelessness or poverty.	www.ccypcg.qld.gov.au
National Association for Prevention of Child Abuse and Neglect (NAPCAN)	NAPCAN's mission is to prevent child abuse and neglect and to ensure the safety and wellbeing of every Australian child.	www.napcan.org.au

Child Family Community Australia (CFCA)	An information exchange operated by the Australian Institute of Family Studies which brings together the former National Child Protection Clearinghouse, Australian Family Relationships Clearinghouse, and Communities and Families Clearinghouse Australia	www.aifs.gov.au/cfca
The Secretariat of National Aboriginal and Islander Child Care (SNAICC)	SNAICC is the national non government peak body in Australia representing the interests of Aboriginal and Torres Strait Islander children and families.	www.snaicc.asn.au
Peakcare Queensland	Peakcare is the peak body for child protection services in Queensland.	www.peakcare.org.au
Community Door	Community Door is a gateway for community-managed organisations in Queensland to access key information to assist in all aspects of the operation of the service	www.communitydoor.org.au

Professional boundary activities

Dovetail has used a range of activities in training events. The following are a few that are relevant for workers considering boundary issues in their practice.

DOVETAIL PROFESSIONAL BOUNDARIES ACTIVITY

Put the following actions or behaviours in order from 1-15 based on how serious you think they are: (1 being the most serious, 15 being the least serious) Note: you cannot put the same number in more than one box.

- ☐ Giving a client your personal mobile number
- ☐ Giving some loose change to a vulnerable client who you bump into whilst walking to your car after a shift has ended so that they can catch bus the home
- ☐ Giving a client a lift home at the end of a shift (their house is on your way home)
- ☐ Touching an upset client on the shoulder to comfort them
- ☐ Giving a client a cigarette
- ☐ Accepting a facebook friendship request from a regular, friendly visitor to your service
- ☐ Letting a client who has nowhere else to go stay at your house for a night until they get keys to their new place the next day
- ☐ When asked, telling a police officer what substances an intoxicated client has had
- ☐ Accepting free tickets to a show from an ex-client who wants to thank you for your recent assistance
- ☐ Talking about a client in an identifiable way to your friends at a BBQ
- ☐ Providing significant emotional counselling to a friend of yours who rocks up to your work
- ☐ Smoking a joint at a party that was passed to you from someone who you recognise as being an ex-client
- ☐ Telling rude jokes to a client
- ☐ Talking about your own personal relationship to a client
- ☐ Having sex with a client whom you met at work

QUESTIONS:

How difficult was it to complete this exercise?

How did you choose the ranking of these situations? What was your decision making process?

Are there any special circumstances or conditions which might make some of the actions more acceptable? If so, what are they?

Are there other situations or circumstances that you have experienced that you would add to this list? If yes, where would you rank them?

DOVETAIL PROFESSIONAL BOUNDARIES SCENARIOS

Read each of the scenarios and answer the following questions:

SCENARIO 1: MONDAY MORNING SURPRISE!

You are a youth worker who provides casework support to young people living in supported accommodation. One Monday morning you go visiting all of your clients (as you regularly do on a Monday morning) and when you knock on one of their doors an old friend of yours opens it, much to your surprise. It turns out that they've started dating one of your clients!

QUESTIONS:

How would you respond in this situation?

What if you used to be in an intimate relationship with your old friend?

SCENARIO 2: BLAST FROM THE PAST

You are single and oh-so available… One day, a client who you first worked with 5 years ago ever-so-briefly on an arts project, bumps into you on the street. You start talking and catching up on how things have been as it has been such a long time since you have seen each other. You are really pleased to hear that the ex-client is doing really well, living independently, in a great job, plus studying and keeping fit etc. In fact, you notice that there is an instant rapport and attraction between you both and it's easily recognisable, especially as the age difference between you both is negligible, less than 12 months. You part company, but a fortnight later you receive an email at work from the person asking you if you would like to catch up for a drink sometime.

QUESTIONS:

How would you respond in this situation?

Are there any risks if you were to pursue this contact?

SCENARIO 3: MISSING IN ACTION

You are at work one day when you notice the 14 year old daughter of a family friend turn up at your service seeking help with getting some emergency relief money for rent, stating that she is actually 17 years old and living independently.

The young woman hasn't seen you and doesn't know that you work there. What you also know is that she is supposed to be at home with her mother, and is actually listed as a "Missing Person". Her mother – who is a friend of yours – is worried sick about the girl's safety and wellbeing. You know they have been fighting for weeks and that the daughter ran away about a week ago.

QUESTIONS:

How would you handle this situation immediately?

What would you do following the shift?

SCENARIO 4: THE CONCERNED COLLEAGUE

You are concerned about a colleague who has not been looking so great lately. You've noticed him out really drunk a few times recently and when he turns up to work he seems sweaty, anxious, agitated, with pressured speech.

Later on that night you are going to the toilet when you notice that there is someone in the cubicle who is taking a long time. The person is clearly doing something in there and you hear clanging of metal and plastic bags being opened and closed – which you suspect to be the sounds of someone injecting.

As you leave the person who comes out of the toilet is your colleague, but he does not see you.

QUESTIONS:

How would you handle this situation immediately?

What would you do following the shift?

DOVETAIL PRIVATE REFLECTION EXERCISE:

There are a huge number of factors that influence how you might act or behave when you are put into certain situations. Factors can be as simple as to how tired or hungry you are, to something that might have happened to you that day, to core and intrinsic values, beliefs and experiences that you have held since childhood.

Reflect on the following questions to get an idea of the sorts of influences, drivers and triggers that affect the way you might act or behave at work.

You will not have to share these answers with anyone.

- **What are your impressions of young people generally?**
- **How do you think they are treated in society? Does this impression affect the way you engage with young people at work?**
- **Why do you do what you do? What are the drivers or motivators behind your choice to work here? Is it:**
  - **Money and conditions?**
  - **Practical experience?**
  - **For recognition? Or sense of personal worth and esteem?**
  - **Because you want to help people?**
  - **Because you believe you have real skills to help young people?**
  - **For religious reasons?**
  - **Because you have personal experience in the field and want to give something back?**
  - **Because you think young people need protecting?**
  - **Because young people's behaviour needs changing or improving?**
  - **Or something else?**
- **What are your triggers? And how do you know when you're being triggered? What are the emotional or physiological signs or symptoms?**
- **What are your warning signs for burn-out? When will you know that it is time for you to resign from your work or find a new job?**

Queensland University of Technology

Dovetail

supporting the youth alcohol and drug sector in Queensland